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English only

Information circular*

To: Members of the staff and participants of the after-service health insurance programme

From: The Controller

Subject: **Renewal of the United Nations Headquarters-administered health insurance programme, effective 1 July 2017**

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* Expiration date of the present information circular: 30 June 2018.

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General

1. The purpose of the present circular is to provide information regarding health insurance plans administered by United Nations Headquarters and to announce the 2017 administrative and plan changes, including premium and contribution rates changes.

2. Changes in the premium and contribution rates will take effect on 1 July 2017 for the following health insurance programmes:

(a) Aetna PPO/POS: increase of 1.00 per cent;

(b) HIP Health Plan of New York: increase of 11.60 per cent;

There will be no premium increase for the Cigna US Dental PPO plan, the Empire Blue Cross PPO plan or the UN Worldwide Plan. Please refer to annex I for more details.

3. The following plan benefit changes will be implemented for the Empire Blue Cross PPO plan effective 1 July 2017:

(a) Reduction in the reimbursement rate for out-of-network physical therapists from 395 per cent of Medicare to 250 per cent of Medicare in order to better align reimbursement practices with current market standards;

(b) Increase in the number of occupational/speech/vision therapy visits from 30 to 60 per calendar year.

4. The following plan benefit change will be implemented for the UN Worldwide Plan effective 1 July 2017:

(a) Introduction of a cap of 60 visits a year for physical therapy and 60 visits a year for combined occupational/speech/vision therapy;

(b) Increase in the annual deductible under the UN Worldwide Plan for medical services received in the United States of America from the current deductible of $1,200 per person/$3,600 per family to $5,000 per person/$15,000 per family.

5. Because of the recent unfavourable claims experience under the Aetna PPO plan, there will be no premium holiday for the plan year 2017/18 in order to avoid an increase in premiums.

6. Staff members and retirees currently enrolled in the UN Worldwide Plan who are considering coverage for family members residing in the United States or who intend to seek medical care in the United States on a regular basis are reminded that they should consider enrolling in a United States-based plan effective 1 July 2017, given that the UN Worldwide Plan does not provide adequate coverage in the United States. In addition, the United Nations health insurance programme requires that staff members, retirees or covered dependants residing in the United States enrol in a United States-based plan. Staff members and retirees who choose to remain in the UN Worldwide Plan will also be subject to the increased limitations and restrictions that will be implemented on 1 July 2017 for the Plan regarding expenses incurred in the United States. Benefit changes introduced in 2013 to deter plan members from receiving medical treatments in the United States have proved ineffective. Please refer to the section on special provisions for the UN Worldwide Plan in the present circular.

7. It will not be possible to cover staff members or retirees in one health insurance plan and cover their eligible dependants in another.

8. Staff members and retirees currently enrolled in the United Nations health insurance programme should note that all carriers are increasing communication to staff members and retirees in an effort to improve their understanding of insurance. Staff members and retirees should therefore expect to receive increased mailings and/or emails.

Costing of United Nations insurance programmes

9. All plans administered by United Nations Headquarters, other than the HIP Health Plan of New York, are self-funded health benefit plans; they are not insured programmes. The cost of the programme is based primarily on the medical services provided to plan participants and directly reflects the level of utilization of the plan benefits by its participants. The yearly contributions paid by the participants and the portion of the premium paid by participating United Nations entities are used to cover claim costs plus a fixed administrative fee per primary subscriber (i.e. staff member or retiree), which represents less than 4 per cent of the total programme cost for the United States-based plans and about 8 per cent for the UN Worldwide Plan. Costs are borne by the plan participants and the Organization as follows:

(a) For United States-based plans, the United Nations and plan participants bear the costs collectively through a "two thirds to one third" cost-sharing arrangement approved by the General Assembly;

(b) For the UN Worldwide Plan, costs are borne by the United Nations and by plan participants collectively through a 50/50 cost-sharing arrangement approved by the General Assembly;

(c) Neither the portions of the monthly premium of plan participants nor those of the organizations are prorated. The full monthly premium amount will be collected regardless of the date on which coverage begins within a month.

10. Aetna, Empire Blue Cross and Cigna provide administrative services to the United Nations on the basis of "administrative services only" agreements entered into by the United Nations with those carriers. Those arrangements make it possible for the United Nations to use the carrier's eligibility and claim-processing expertise, and benefit from the direct billing and discounted services that the carriers have negotiated with medical providers in their networks.

11. Except for HIP, the United Nations medical insurance and dental insurance programmes are "experience-rated". This means that each year's premiums are based on the cost of medical or dental treatment received by United Nations participants in prior years, plus the expected effect of higher utilization and medical inflation, plus the appropriate allowance for administrative expenses for the new plan year. The underlying elements in the increasing cost of health insurance for participants are therefore:

(a) Continuing growth in utilization of services and medications;

(b) Continuing increases in prices for services and medications;

(c) Expenses that are incurred in high-cost health-care markets.

12. In a year following periods of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been moderate, the premium increase in the subsequent year is also likely to be moderate. The yearly premiums are calculated to meet medical expenses and administration costs in the forthcoming 12-month contract period. Each year the expected overall costs of the programme are first expressed as premiums and then borne collectively by the participants and by the Organization in accordance with the cost-sharing ratios set by the General Assembly.

13. To contain premium increases, all participants of the United Nations health insurance plans are expected to be educated consumers. Expenses must be incurred for medically necessary services and treatments, and not for the convenience of the doctor or patient. Participants are expected to be mindful of the cost of the services and treatments being sought and to ensure that costs are given due consideration in making medical choices without necessarily sacrificing the quality and effectiveness of treatments. In the United States, it means that every effort should be made to select in-network providers, given that out-of-network providers charge higher costs and expose the patient to financial risk, since the plans will cap reimbursements on the basis of a reasonable and customary rate and not the actual provider's charges.

14. The HIP plan is "community-rated". This means that HIP premiums are based on the average medical cost of all employers that purchase the same kind of coverage from HIP and not just that of United Nations participants. The New York State Insurance Department regulates the premium rates for community-rated programmes, such as HIP.

15. Each plan in the United Nations Headquarters health insurance programme provides protection against the high cost of health care, whether it involves preventive care, management of chronic conditions, serious illness or injury. Premiums collected are pooled together, from which the claims are paid. To ensure the viability and affordability of the plans, subscribers are expected to participate and contribute to the plan through the regular payment of premiums, regardless of their current health condition and need for coverage. Strict rules for enrolment in, and termination from, the plan have been put in place to prevent abuse and participation on an "as needed" basis only. Rebates based on a person's consumption are not permitted.

16. Cost containment is also available through wellness initiatives. Health improvements and cost reductions have begun to become apparent as staff and retirees use the condition management and wellness features available to Aetna and Empire Blue Cross participants through the ActiveHealth programme implemented in December 2008. Plan participants are encouraged to make full use of the ActiveHealth programme, especially by accessing the MyActiveHealth website, so as to obtain maximum benefits from both a health/wellness perspective and a plan cost perspective.

Annual campaign

17. The annual campaign for 2017 is being held from 31 May to 30 June 2017 and is open to active staff members only. Staff members may log on to the Umoja employee self-service portal to make changes to their coverage, which may include changing health insurance plan, adding a family member who was not previously covered or terminating coverage for a currently covered family member. Such action should be completed by 30 June, as the system will automatically end the campaign period on that date. After 30 June, no further actions can be completed without a qualifying work or life event. The staff members of the Health and Life Insurance Section are available to provide information and answer specific questions regarding the health plans being offered to staff, by email or in person, every day through the Insurance and Disbursement Service client services at the location and hours indicated below:

Room FF-300, 304 East 45th Street, New York, New York 10017

Client service hours:

1-4 p.m.	Monday through Friday
Email:	insurance-unhq@un.org
Website:	www.un.org/insurance
Tel.:	212 963 5804 (for general enquiries)
Fax:	917 367 1670

18. The 2017 annual campaign is the only opportunity until the next annual campaign, in May 2018, to: (a) enrol or terminate enrolment in the United Nations Headquarters-administered insurance programme; (b) change to another plan; and/or (c) add or terminate coverage for eligible dependants from their plan, aside from the specific qualifying events, such as marriage, divorce, death, birth or adoption of a child and transfer within the United Nations system, for which special provisions for enrolment between campaigns are established. Paragraphs 37 and 38 of the present circular provide information on the qualifying events for enrolment and termination outside the annual campaign period.

19. A staff member enrolled in any of the health insurance plans must continue such coverage for at least 12 months before elections for discontinuation of coverage during the annual campaign will be accepted. Staff members enrolled in the UN Worldwide Plan who transfer to the Aetna or Empire Blue Cross plan as a result of covered family members residing in the United States must remain in the new plan for at least 12 months before elections to return to the UN Worldwide Plan will be accepted.

20. Individuals enrolled in the Headquarters-administered after-service health insurance may make a change between either United States-based plan once every two years only, in accordance with section 8.2 of administrative instruction ST/AI/2007/3 on after-service health insurance.

21. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, is 1 July 2017.

22. Staff members who switch coverage between the Aetna and Empire Blue Cross plans and who have met the annual deductible or any portion thereof under either of those plans during the first six months of the year may be credited with such deductible payment(s) under the new plan for the second six months of the year, under certain conditions. The deductible credit will not occur automatically and can be implemented only if the staff member:

(a) Formally requests the deductible credit on the special form designed for that purpose;

(b) Attaches the original explanations of benefits attesting to the level of deductibles met for the calendar year by the staff member and/or each eligible covered dependant.

The deductible credit application form may be obtained from the Health and Life Insurance Section (www.un.org/insurance/forms). The completed form must be submitted to the Section (not to Aetna or Empire Blue Cross) by email to ids@un.org, together with the relevant explanations of benefits, no later than 31 August 2017 in order to receive such deductible credit.

Coordination of benefits

23. The United Nations insurance programme does not reimburse the cost of services that have been or are expected to be reimbursed under another insurance, social security or similar arrangement. For those members covered by two or more plans, the United Nations insurance programme coordinates benefits to ensure that the member receives as much coverage as possible, but not in excess of expenses incurred. Members covered under the United Nations insurance programme are expected to advise the insurance carriers when a claim can also be made against another insurer. Benefits are coordinated as follows:

(a) Aetna and Empire Blue Cross conduct coordination of benefits exercises as part of the administrative services that they provide to the United Nations;

(b) Empire Blue Cross conducts its own exercises by mailing out annual questionnaires to members, and Aetna uses the services of the Rawlings Company to conduct its exercises.

Plan participants are required to complete and return all questionnaires sent to them by insurance carriers.

Fraud and abuse

24. Fraud or abuse of the plan by any member (i.e. active staff member or retiree and their covered family members) will result in the immediate recovery of moneys and disciplinary measures in accordance with the Staff Rules and Regulations of the United Nations and other administrative directives. Such measures may include the forfeiture or suspension of participation in any health insurance plan of the Organization or suspension from receiving any subsidy from the Organization. Any fraud committed by subscribers and/or their eligible covered family members may also be referred to the relevant national authorities by the Organization.

25. Fraud or abuse of the plan by any provider will be handled according to the applicable procedures of the insurance carrier and may be referred to the local authorities. Members are strongly encouraged to review their explanation of benefits or claim statement carefully in order to ensure that only services received from their provider are billed, and to report any questionable charges to the insurance carriers so that those can be investigated.

Eligibility and enrolment rules and procedures

26. All staff members holding appointments of three months or longer may enrol themselves and eligible family members in the United Nations insurance programme. In addition, staff members holding temporary appointments with one or more extensions that, when taken cumulatively, will amount to three months or more of continuous service can enrol themselves and eligible family members from the beginning of the contract that will meet the three-month minimum threshold.

27. Staff members holding temporary appointments of less than three months are eligible to enrol in the United Nations short-term medical insurance plan administered by Cigna on an individual basis only. Information regarding the insurance programme for temporary appointments of less than three months can be obtained from the Health and Life Insurance Section. Staff members enrolled in the short-term medical insurance plan will be required to transfer to one of the regular medical insurance plans upon extension of such temporary appointment beyond three months.

28. Staff members on a "when actually employed" appointment are not eligible to enrol in the health insurance programme.

29. Post-retirement appointees who are covered under the United Nations plans in accordance with the after-service health insurance provisions may continue such coverage, except when they are re-employed by the United Nations or any other member organization of the United Nations Joint Staff Pension Fund and their service period requires re-entry into the Pension Fund as a contributing participant. A post-retirement appointee who returns to service and re-enters the Pension Fund as a contributing participant must discontinue his or her after-service health insurance coverage and enrol in the health plan as an active staff member. If the staff member is employed by an organization that uses Umoja, enrolment must be carried out through the employee self-service portal during the eligibility period. At that time, the staff member may retain his or her level of coverage or change the level of coverage if so desired. After-service health insurance coverage will resume upon separation from service and reapplication within 31 days of such separation, but at the level of coverage that existed on the initial after-service health insurance application. Failure to reapply within 31 days of separation will result in a gap in health insurance coverage for the post-retirement appointee, and reinstatement will be made only when all outstanding after-service health insurance contributions are paid in full.

30. "Eligible family members" referenced in the present circular do not include secondary dependants, family members of temporary staff members with appointments of less than three months or family members of occasional workers. The term "eligible family members" refers to a recognized spouse and one or more dependent children. The United Nations health insurance programme recognizes only one eligible spouse for coverage. A dependent child is one who meets the definition under staff rule 3.6 (a) (iii) and is reflected as a household member in the Umoja system of the United Nations, the Atlas system of the United Nations Development Programme (UNDP), the SAP system of the United Nations Children's Fund (UNICEF) and the "oneUNOPS" system of the United Nations Office for Project Services (UNOPS) in order to be eligible.

31. A child is eligible to be covered under the programme until the end of the calendar year in which he or she attains the age of 25 years, provided that he or she is not married or employed full-time. Children with disabilities may be eligible for continued coverage beyond the age of 25 years provided that they are certified disabled by the Medical Services Division, if the parent is an active staff member, or by the United Nations Joint Staff Pension Fund, if the parent is a retiree.

32. Staff members, in particular those who have no coverage under a United Nations plan or are covered through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members during the annual campaign or after a qualifying event, especially given that the high cost of medical care could result in financial hardship for individuals who fall ill and/or are injured and have no such coverage. Injury or illness is not a qualifying event for enrolment in the United Nations health insurance programme.

Staff member married to another staff member

33. In the case of a staff member married to another staff member, both staff members may elect to maintain their own individual insurance coverage at the "staff member only" coverage level. In the case of coverage at the two-person, i.e. "staff member plus spouse", or family level, where both staff members are to be covered, such coverage must be carried by the higher-salaried staff member. In cases in which married staff members are assigned to different duty stations, have dependent child(ren) and wish to maintain separate health insurance coverage, the staff member in receipt of the dependency allowance must carry the insurance for the dependent child(ren).

34. The determination of the higher-salaried staff member is based on the "medical net" salary of both staff members. "Medical net" salary is calculated as gross salary, less staff assessment, plus transitional allowance, single parent allowance, dependent spouse allowance, post adjustment, language allowance and non-resident allowance, as applicable. In the case in which both staff members in the same duty station belong to the same category and grade, the higher-salaried staff member will be the one who is at least four steps higher than the other; otherwise, either one may carry the two-person or family coverage.

35. The only exception to the policy above is in the case of a staff member on a temporary appointment of less than 364 days married to another staff member on a fixed-term, continuing or permanent appointment and belonging to the same category. In that case, the insurance coverage at the two-person or family level must be carried by the staff member whose appointment is not temporary.

36. It should also be noted that, if one spouse retires from service with the Organization before the other, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance benefits following separation from service. The retiring staff member must nevertheless submit an application for after-service health insurance to the Health and Life Insurance Section in order to preserve his or her right to exercise the benefit in the future.

Enrolment between annual campaigns

37. Between annual campaigns, staff members and their eligible family members may be allowed to enrol in the Headquarters-administered medical and dental insurance plans only if at least one of the following qualifying events occurs and enrolment is completed within 31 days of such occurrence through the Umoja employee self-service portal, for United Nations staff, or through the submission of a completed application form, for staff of the United Nations agencies participating in the United Nations health insurance programme:

(a) In respect of medical insurance coverage, upon receipt of an initial fixed-term or temporary appointment of at least three months' duration at Headquarters and, in the case of temporary appointees, upon achieving a threshold duration of continuous active employment at a minimum of half-time for at least three months;[1]

(b) In respect of dental insurance coverage, upon receipt of an initial fixed-term or temporary appointment of at least three months' duration at Headquarters;[1]

(c) Upon transfer or assignment of the staff member to a new duty station, even if of a temporary nature;[1] however, if the staff member is already enrolled in a United Nations insurance programme and wishes to change plans because of the transfer, he or she may do so without changing the eligible family member(s) already covered under his or her existing plan;

(i) For staff members with eligible family members who are residing in a different location, coverage must be initiated during this eligibility window in alignment with the Umoja employee self-service enrolment period;

(d) Upon return from special leave without pay, but only under the health insurance plan and coverage type in which the staff member was insured before taking leave (i.e. no opportunity to enrol eligible family members if they were not

[1] If coverage for eligible family members is desired, such enrolment must be done at the same time as the staff member's application even if the dependants have not arrived at the duty station.

covered before taking leave, with the exception of the events referred to in subparagraphs (f) and (g) below that occur during the period of special leave);

(e) Upon reinstatement of appointment in accordance with staff rule 4.18;

(f) Upon marriage, in the case of spouses, provided that the staff member is currently enrolled;

(g) Upon birth or legal adoption, in the case of children, provided that the staff member is currently enrolled;

(h) Upon presentation of proof of loss of coverage by the staff member under a spouse's health insurance plan, in accordance with paragraph 59 below;

(i) Upon the provision of evidence that the staff member was on official travel or on annual or sick leave for the entire duration of the annual campaign and enrolment is completed through the Umoja employee self-service portal for United Nations staff and the submission of a completed application for staff of United Nations agencies participating in the health insurance programme within 31 days of his or her return to the duty station.

38. Staff members and their eligible dependants may terminate their coverage under the medical and dental plans between annual campaigns only if one of the following qualifying events occurs and application for termination is made within 31 days of such occurrence:

(a) Upon divorce, in the case of a spouse;

(b) Upon the death of a covered dependant;

(c) Upon the marriage or full-time employment of a covered child;

(d) Upon employment of a spouse with the Secretariat or a United Nations system organization on a non-temporary appointment at a higher grade and level and eligibility for medical insurance coverage. Employment of a spouse with any other employer will not be considered a qualifying event for termination from a United Nations health insurance plan.

39. In all the cases cited in the paragraphs above, enrolment, re-enrolment or termination must be completed through the Umoja employee self-service portal within 31 days of the occurrence of the event giving rise to the entitlement to enrol. Enrolment between annual campaigns based on any other circumstances not listed in paragraphs 37 and 38 above or not processed through the employee self-service portal within 31 days of the event giving rise to eligibility will be denied. Staff members who, for any reason, are uncertain as to the continuity of any outside coverage are urged to consider enrolling in a United Nations scheme during the current campaign period.

Staff on special leave without pay

40. Staff members granted special leave without pay may retain coverage for medical and dental insurance during such periods or may elect to discontinue such coverage for the period of the special leave, under the following conditions:

(a) **Insurance coverage maintained during special leave without pay**. If the staff member decides to retain coverage during the period of special leave without pay, the Health and Life Insurance Section must be informed directly by the staff member in writing of his or her intention at least 31 days in advance of the commencement of the special leave. At that time, the Section will require evidence of approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (i.e. both the staff member's contribution and

the Organization's share, given that no subsidy is payable during such leave). If the leave period exceeds six months, premiums may be paid in instalments every six months. Failure to pay the required premiums in advance shall result in termination of coverage without further notice to the staff member concerned. Staff members may be allowed to transfer to a health insurance plan that is more appropriate to where he or she will reside during the period of special leave, provided that such leave is at least six months in duration. However, staff members enrolled in the UN Worldwide Plan before taking special leave and planning to reside in the United States during the period of special leave may enrol in the Aetna or Empire Blue Cross and Cigna Dental plans;

(b) **Staff members maintaining individual insurance coverage**. If a staff member going on special leave without pay has individual insurance coverage and is married to another staff member with individual insurance coverage, the staff member going on leave may be covered under the policy of his or her spouse who remains in active service;

(c) **Insurance dropped while on special leave without pay**. Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, the staff member cannot re-enrol until he or she returns to work;

(d) **Re-enrolment upon return to duty following special leave without pay**. Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) through the Umoja employee self-service portal, if a United Nations staff member, or by email with a completed and signed application form, if a staff member of a United Nations agency, upon return to duty. This must be done within 31 days of return to duty. There is no automatic reinstatement of coverage following return from special leave without pay. Failure to re-enrol will result in the staff member being unable to resume participation in the insurance plan(s) until the next annual enrolment campaign. The staff member will be allowed to re-enrol only under the health insurance plan and coverage type in which he or she was insured before taking leave, in accordance with paragraph 38 (d) above.

Staff on special leave with half or full pay and staff on part-time employment

41. Staff members on special leave with full or half pay shall continue to be covered in their health insurance plan in effect before the leave period. However, staff on special leave with half pay for more than 31 days and staff with part-time employment status that involves a full calendar month shall be subsidized by the Organization at half the regular amount, and the staff member shall be responsible for the other half in addition to his or her regular insurance contribution.

Special provisions for the UN Worldwide Plan

42. The UN Worldwide Plan covers current and former staff members who reside anywhere other than in the United States. Current and former staff members and their dependants who reside in the United States are not eligible for coverage under the UN Worldwide Plan, given that it does not provide adequate coverage in view of the cost of health care in the United States. It is therefore expected that a request to change insurance plans will be initiated within 31 days of a situation change, pursuant to the appropriate procedure in place at the time of the event.

43. The sole exception to this exclusion arises in the case of a dependent child who attends school or university in the United States and is required by the educational institution to enrol in its health insurance plan. In this case, the student's health insurance plan at the school or university will be primary and the UN Worldwide Plan will be secondary. It should be noted that the United States

dental plan is separate from the medical plans. If dental coverage is desired, the dental plan must be selected in the Umoja employee self-service portal, for United Nations staff, or the dental portion of the group medical and dental insurance application form should be properly filled out, for United Nations agency staff.

44. Staff members covered under the UN Worldwide Plan should not seek medical care in the United States because the plan does not offer adequate medical protection owing to the annual reimbursement limit of $250,000 and the high cost of medical care in the United States, which is not reflected in the plan's premiums. Participants who seek non-emergency medical care in the United States on a regular basis are required to transfer to a United States-based plan during the annual campaign.

45. Medical treatment obtained in the United States is subject to all restrictions and limitations of the UN Worldwide Plan, and staff members will be responsible for the payment of all amounts that exceed benefit limits and annual maxima. Each plan member will be responsible for the first $5,000 per person or $15,000 per family every year before the plan begins to pay for medical services received in the United States. Furthermore, expenses incurred in the United States will not be subject to the Major Medical Benefits Plan. Prior notification is mandatory and will allow the third party administrator of the UN Worldwide Plan to propose alternatives and negotiate significant discounts. Participants who fail to receive prior approval from Cigna for care in the United States will be subject to the deductibles and Major Medical Benefits Plan restrictions stated above. Staff members and their eligible family members cannot be covered under separate health insurance plans.

46. The claim costs in the UN Worldwide Plan are incurred in all parts of the world. Consequently, they reflect varying price levels. Three premium rate groups have been established to enable the determination of premiums that are broadly commensurate with the expected overall level of claims for the locations included within each rate group. The applicable rate group is based on the staff member's duty station regardless of whether the covered family members are residing in the same duty station or if care is sought primarily outside the duty station.

Participant's address for insurance purposes

47. It is the responsibility of a staff member or retiree to ensure that his or her correct, complete and up-to-date mailing address is stored in the system of record of his or her organization (i.e. Umoja for the United Nations, Atlas for UNDP, SAP for UNICEF and oneUNOPS for UNOPS). Given that addresses are a part of a staff member's personnel profile, United Nations staff members should update their address in the Umoja employee self-service portal, and UNDP, UNICEF and UNOPS staff should contact their respective global service centres to provide or update their address. Retirees must email their address updates to ashi@un.org. The insurance carriers recognize only the addresses that are electronically transmitted to them by the United Nations from the above-mentioned systems. For those residing in the United States, it is also essential that the address bear the proper United States postal abbreviation for states (e.g. New York and New Jersey must be designated as NY and NJ, respectively) and zip codes. Incomplete address information will result in the insurance carriers rejecting the data transmission, as well as in misdirected mail and failure to receive important correspondence, identification cards or even benefit cheques.

Effective commencement and termination date of health insurance coverage

48. Provided that enrolment is completed within the prescribed 31-day time frame, coverage for a staff member newly enrolled in a health insurance plan begins on the first day of a qualifying contract or the first day of the following month. When a contract terminates before the last day of a month, coverage will remain in place until the last day of that month. As mentioned previously, premiums are not prorated.

49. Any expenditure, including that related to ongoing treatment, incurred after the expiry of coverage will not be covered by the United Nations health insurance programme.

Employment-related illness or injury

50. In the event of illness or injuries that may be attributable to the performance of official duties, the resulting medical and related expenses are payable under appendix D to the Staff Rules (rules governing compensation in the event of death, injury or illness attributable to the performance of official duties on behalf of the United Nations). In such cases, medical expenses can be paid initially under the health insurance plan of the affected staff member, subject to the subsequent offset by the United Nations of any amount payable under the provisions of appendix D. Nevertheless, staff members must still submit a claim addressed to the Secretary of the Advisory Board on Compensation Claims and the Claims Board.

Movement between organizations, breaks in appointment and movement between payrolling offices

51. Coverage is terminated automatically but not restored automatically for staff members who:

(a) Are separated from service;

(b) Transfer between organizations under a loan, transfer or secondment arrangement (e.g. United Nations, UNDP and UNICEF);

(c) Are reappointed, regardless of whether there was a break in employment, or following a change in employment contract/appointment;

(d) Transfer to a non-Umoja payrolling organization.

52. Most individuals whose contracts end do, in fact, leave the United Nations common system. However, many insured staff members are reappointed or transferred between the United Nations, UNDP and UNICEF. Those staff members must reapply for health insurance coverage within 31 days of the effective date of the reappointment or transfer. Strict attention to this requirement is necessary to ensure continuity of health insurance coverage because, as noted, separation from an organization results in the automatic termination of insurance coverage at the end of the month. Staff members who transfer between organizations should also ensure that the receiving organization establishes their household members and mailing address in its database so that coverage can be reinstated under the receiving organization.

Medical assistance service during personal travel

53. United Nations health insurance plans provide coverage to staff members while they are outside their duty station, including while on personal travel. For United States-based participants enrolled under the Aetna and Empire Blue Cross

plans, UnitedHealthcare Global Assistance and Risk provides emergency medical assistance when they are 100 miles or more away from home.

54. Staff members and retirees are reminded that, when they are undertaking personal travel, repatriation and evacuation costs are not covered under any of the United Nations health insurance plans or by UnitedHealthcare Global Assistance and Risk. Travellers should consider purchasing travel insurance that provides such benefits at their own cost.

55. For participants requiring a certificate of insurance coverage, such as that required for applications for visas to certain countries, a request for such a certificate may be sent to ids@un.org. Certain countries may not accept certifications by the United Nations and may require individuals to purchase travel insurance.

Cessation of coverage of the staff member and/or family members

56. Staff members are required to immediately notify the Health and Life Insurance Section of changes that result in a family member ceasing to be eligible, for example a spouse upon divorce or a child marrying or taking up full-time employment. Other than with regard to children reaching the age of 25 years, the responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. Discontinuation of coverage must be completed in the Umoja employee self-service portal within 31 days of the qualifying event.

57. Staff members wishing to discontinue their coverage, or that of an eligible family member, must communicate the instruction to the Health and Life Insurance Section in writing within 31 days of the qualifying event, even before the approval of the related personnel action. It is in the interest of staff members and retirees to process changes promptly in order to benefit from any reduction in premium contribution that may result. Irrespective of when a change is processed or when written notification is given, termination of coverage will be implemented on the first of the month after a family member ceases to be eligible for participation in the health insurance programme. No retroactive refund of contribution can be made as a result of the staff member's failure to take action or to provide timely notification of any change to the Section.

58. In the case of children with disabilities over the age of 25 years, eligibility for health insurance coverage shall cease as a result of emancipation, marriage, full-time employment, lapse of disability certification by the Medical Services Division or cessation of a pension or compensation benefit, whichever comes first. It is the staff member or retiree's responsibility to ensure that disability certifications for his or her disabled child(ren) are up to date. Such children will not be allowed to continue coverage under the health insurance plans while such certifications are being requested.

Insurance enrolment resulting from loss of employment of a spouse

59. Loss of coverage by a staff member covered under a spouse's health insurance plan owing to the spouse's loss of employment beyond his or her control (i.e. layoffs, mandatory retirement, downsizing as a result of full or partial cessation of operations or relocation of offices, but not resignation or voluntary change to part-time employment) is considered a qualifying event for the staff member's enrolment in a United Nations Headquarters programme, provided that the staff member is otherwise eligible to participate in the programme. Application for enrolment in a United Nations plan under these circumstances must be made within 31 days of the qualifying event and must be accompanied by an official letter from the spouse's

employer certifying the reason for termination of employment and the effective and end dates and type of insurance coverage.

After-service health insurance

60. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, the applicant must be enrolled in a United Nations scheme at the time of separation from service. Enrolment in the after-service health insurance programme is not automatic. Application for enrolment must be made within 31 days before, or immediately following, the date of separation. Full details on the eligibility requirements and administrative procedures relating to after-service health insurance coverage are set out in administrative instruction ST/AI/2007/3 on after-service health insurance.

61. In the case of the death of a staff member, information on continuation of coverage for a surviving spouse and/or dependent children can be found in administrative instruction ST/AI/2007/3.

62. Since 1 January 2011, United Nations Headquarters has required all former staff members and dependants (including surviving spouses and eligible dependent children) who are enrolled as participants in the after-service health insurance and who qualify for participation in Medicare Part B to enrol in the United States Medicare Part B programme. Those retirees who are eligible to enrol in Medicare Part B but choose not to do so will have their claims adjudicated as though they were enrolled. For United States-based retirees, full details on the requirements of the Medicare Part B programme are set out in information circular ST/IC/2011/3.

Conversion privilege

63. Following the passage of the Affordable Care Act in the United States and the offering of health insurance plans in the state or federal marketplace exchanges, the United Nations United States-based plans no longer offer private plans under what was previously referred to as the "conversion privilege". Staff members (subscribers) who cease employment with the United Nations and do not qualify for after-service health insurance benefits, or formerly covered spouses or children, are directed to the insurance exchanges operated by their states of residence or the federal Government to arrange for medical coverage under an individual contract.

64. The health insurance plans offered in the insurance exchanges do not require presentation of certification of medical eligibility (also referred to as "medical underwriting"). The exchanges offer different plans according to the needs of the individual. The Health and Life Insurance Section does not have information on individual plans offered in the various exchanges, nor can it provide advice on which plans are appropriate for a staff member or his or her family member's needs. It is the staff member's responsibility to assess the plans on offer. The plans are available only for residents of the United States.

65. Staff members and their family members who are covered under the UN Worldwide Plan may contact Cigna International directly to enquire about available plans that they may purchase on their own following loss of coverage under the UN Worldwide Plan. Staff members must contact Cigna International as soon as coverage is terminated (normally within 31 days of such termination). Details on available plans should be obtained directly from Cigna International.

Time limits for filing claims

66. Subscribers should note that claims for reimbursement of medical services under the Aetna and Empire Blue Cross plans and the UN Worldwide Plan must be

received by the administrators of the plans no later than two years from the date on which the medical expense was incurred. Claims for reimbursement of dental services under the Cigna dental plan must be received no later than one year from the date on which the dental expense was incurred. Claims received by the third party administrators after the above-mentioned grace periods will not be eligible for reimbursement.

Claim payments issued by cheque

67. Subscribers who receive reimbursements by cheque are responsible for the timely cashing of those cheques. Neither the insurance carriers nor the Health and Life Insurance Section will reprocess uncashed cheques more than two years old.

Claims and benefit enquiries and disputes

68. Claims questions must be addressed directly to the insurance company concerned. In the case of disputed claims, the staff member must exhaust the multi-level appeal process with the insurance company before requesting assistance from the Health and Life Insurance Section. The process is indicated in the explanation of benefits or denial letter mailed to the member by the insurance company and the applicable member plan description documents. Members must strictly observe the time limits for submitting appeals to the insurance companies. The addresses and relevant telephone numbers of the insurance companies are listed in annex X to the present circular. Appeals relating to costs in excess of reasonable and customary charges or maximum allowable amounts in accordance with the relevant insurance plan or use of an out-of-network provider in the case of United States-based plans shall not be considered by the Section. Appeals as a result of failure to submit requests to the insurance company or to observe time limits for submitting appeals likewise shall not be considered by the Section.

69. Information about the plans can be found in the plan outlines in the annexes to the present circular and the member plan description documents that can be found on the website of the Health and Life Insurance Section (www.un.org/insurance/circulars). Staff members are responsible for familiarizing themselves with the provisions of the plans in which they elect to enrol. More detailed descriptions of the benefits under the various plans in the United Nations health insurance programme, including most exclusions and limitations, can be found in the member plan descriptions available on the Section's website. In the event of a claim dispute, the resolution of such a dispute will be guided by the terms and conditions of the policy or contract in question. The final decision rests with the insurance company (in the case of HIP).

Websites of the Health and Life Insurance Section and the insurance providers

70. The website of the Health and Life Insurance Section can be accessed at www.un.org/insurance. It provides information about the United Nations programmes, as well as the relevant forms. Detailed descriptions of the Aetna, Empire Blue Cross, Cigna US Dental, UN Worldwide and ActiveHealth programmes are also posted there.

71. Each insurance company in the United Nations health insurance programme has its own website providing a wide range of information about the plan, such as:

(a) Health-care providers;

(b) Physicians;

(c) Participating hospitals;

(d) Pharmacies;

(e) Vendors of prosthetics, orthotics, durable medical equipment and medical supplies;

(f) Dentists;

(g) Health education;

(h) Covered services;

(i) Replacement insurance cards;

(j) Explanations of benefits or claims processed;

(k) Mobile applications available for download to a plan participant's smartphone.

The provider contact directory contained in annex X provides the Internet address of each carrier, as well as related instructions.

Annex I

Premiums and contribution rates

Headquarters-administered medical and dental insurance schedule of monthly premiums* and contribution rates**

(Effective 1 July 2017)

(Premium rates in United States dollars)

	Aetna Open Choice PPO POS II		*Empire Blue Cross PPO*		*HIP*[a]		*Cigna US Dental PPO with Aetna, Empire Blue Cross or HIP*		*Cigna US Dental PPO alone*
Type of coverage	*2016 rates*	*2017 rates*	*2016 rates*	*2017 rates*	*2016 rates*	*2017 rates*	*2016 rates*	*2017 rates*	*2017 rates*
Staff member only									
Premium rate	999.00	1 009.00	747.00	747.00	827.00	923.49	63.40	63.40	63.40
Contribution rate (percentage)	5.28	5.33	3.90	3.90	5.10	5.69	0.32	0.32	0.45
Staff member and one child									
Premium rate	1 995.00	2 015.00	1 491.00	1 491.00	1 510.00	1 686.26	126.80	126.80	126.80
Contribution rate (percentage)	9.24	9.33	6.90	6.90	7.80	8.70	0.56	0.56	0.79
Staff member and spouse									
Premium rate	1 9950	2 015.00	1 491.00	1 491.00	1 510.00	1 686.26	126.80	126.80	126.80
Contribution rate (percentage)	9.24	9.33	6.90	6.90	7.80	8.70	0.56	0.56	0.79
Staff member and two or more eligible family members									
Premium rate	2 496.00	2 521.00	2 165.00	2 165.00	2 405.00	2 684.57	204.74	204.74	204.74
Contribution rate (percentage)	10.32	10.42	8.80	8.80	10.94	12.21	0.86	0.86	1.35

[a] Effective 1 July 2013, the HIP Health Plan of New York is closed to new subscribers (i.e. staff members or retirees). Subscribers who are currently covered may remain in the plan, and any changes related to eligible household members will be accepted. However, a current subscriber who transfers to another United States plan during the 2017 annual campaign will not be allowed to return to the HIP plan in future annual campaigns.

* The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization.

** Staff members may determine their exact contribution by multiplying their "medical net" salary by the applicable contribution rate above. "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus transitional allowance, single parent allowance, dependent spouse allowance, post adjustment, language allowance and non-resident allowance. Actual contributions are capped at 85 per cent of the corresponding premium.

UN Worldwide health insurance schedule of monthly premiums*** and contribution rates****

(Effective 1 July 2017)

Type of coverage	*Monthly premium (United States dollars)*		*Contribution rate (percentage)*	
	Effective		*Effective*	
	July 2016	*July 2017*	*July 2016*	*July 2017*
Rate group 1[a]				
Staff member only	159.00	159.00	1.51	1.51
Staff member and one family member	339.00	339.00	2.33	2.33
Staff member and two or more eligible family members	558.00	558.00	3.67	3.67
Rate group 2[b]				
Staff member only	273.00	273.00	2.31	2.31
Staff member and one family member	576.00	576.00	3.73	3.73
Staff member and two or more eligible family members	950.00	950.00	5.86	5.86
Rate group 3[c]				
Staff member only	262.00	262.00	2.41	2.41
Staff member and one family member	553.00	553.00	3.88	3.88
Staff member and two or more eligible family members	910.00	910.00	6.11	6.11

[a] Rate group 1 includes all locations outside the United States of America other than those listed under rate groups 2 and 3.

[b] Rate group 2 includes Chile and Mexico.

[c] Rate group 3 includes Andorra, Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the United Kingdom of Great Britain and Northern Ireland.

*** The cost is shared between the participants and the Organization.

**** Staff members may determine their exact contribution by multiplying their "medical net" salary by the applicable contribution rate above. "Medical net" salary is calculated as gross salary, less staff assessment, plus transitional allowance, single parent allowance, dependent spouse allowance, post adjustment, language allowance and non-resident allowance, as applicable. The applicable rate group is based on the staff member's duty station. Actual contributions are capped at 85 per cent of the corresponding premium.

Annex II

United States-based medical benefits: plan comparison chart*

	In-network			*Out-of-network*	
Benefits	*HIP Health Plan of New York (in-network only)*	*Aetna*	*Empire Blue Cross*	*Aetna*	*Empire Blue Cross*
Annual deductible	$0.00	$0.00	$0.00	Individual: $250 Family: $750	Individual: $250 Family: $750
Insurance coverage	100 per cent	100 per cent	100 per cent	80 per cent after deductible	80 per cent after deductible
Annual out-of-pocket maximum	Not applicable	Not applicable	Not applicable	Individual: $1,500 Family: $4,500 (with deductible)	Individual: $1,250 Family: $3,750 (with deductible)
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Claim submission	Provider files	Provider files	Provider files	You file	You file
Hospital benefits					
Inpatient Pre-registration required	100 per cent	100 per cent	100 per cent	100 per cent	United States: 80 per cent after deductible International: 100 per cent
Outpatient	100 per cent	100 per cent	100 per cent	100 per cent	United States: 80 per cent after deductible International: 100 per cent
Emergency room (initial visit)	100 per cent accidental injury; sudden and serious medical condition	100 per cent after $75 co-pay (waived if admitted within 24 hours)	100 per cent after $75 co-pay (waived if admitted within 24 hours)	100 per cent after $75 co-pay (waived if admitted within 24 hours)	100 per cent after $75 co-pay (waived if admitted within 24 hours)
Emergency room visit (for non-emergency care)	Not covered but 100 per cent after $35 co-pay at urgent care centres in the United States	80 per cent	Not covered	80 per cent after deductible	Not covered

* A more detailed summary of benefits for each plan is contained in the succeeding annexes and applicable summary plan descriptions available from www.un.org/insurance/circulars.

	In-network			*Out-of-network*	
Benefits	*HIP Health Plan of New York (in-network only)*	*Aetna*	*Empire Blue Cross*	*Aetna*	*Empire Blue Cross*
Medical benefits					
Office/home visits	100 per cent	100 per cent after $15/$20 primary care physician/ specialist co-pay	100 per cent after $15/$20 primary care physician/ specialist co-pay	80 per cent after deductible	80 per cent after deductible
Routine physical	100 per cent once every 12 months	100 per cent after $15 co-pay once every 12 months	100 per cent after $15 co-pay once every 12 months	80 per cent after deductible once every 12 months	80 per cent after deductible once every 12 months
Surgery	100 per cent	100 per cent	100 per cent	80 per cent after deductible	80 per cent after deductible
Prescription drugs					
Pharmacy	$5.00 for generic/brand per 30-day supply	20 per cent co-pay up to $20 per 30-day supply for generic 25 per cent co-pay up to $30 per 30-day supply for brand name	20 per cent co-pay up to $20 per 30-day supply for generic 25 per cent co-pay up to $30 per 30-day supply for brand name	United States: 60 per cent after deductible International: 80 per cent after deductible	United States: 60 per cent after deductible International: 80 per cent after deductible
Mail order	$2.50 for generic/brand per 30-day supply	100 per cent after $15 co-pay per 90-day supply	100 per cent after $15 co-pay per 90-day supply	Not applicable	Not applicable
Behavioural health-care benefits (must be pre-certified; benefit maximum for in-network and out-of-network combined)					
Inpatient mental health care	100 per cent	100 per cent	100 per cent	100 per cent after deductible	80 per cent after deductible
Outpatient mental health care	100 per cent	100 per cent	100 per cent	80 per cent after deductible	80 per cent after deductible
Inpatient alcohol and substance abuse care	100 per cent	100 per cent	100 per cent	100 per cent after deductible	80 per cent after deductible
Outpatient alcohol and substance abuse care	100 per cent	100 per cent	100 per cent	80 per cent after deductible	80 per cent after deductible

	In-network			*Out-of-network*	
Benefits	*HIP Health Plan of New York (in-network only)*	*Aetna*	*Empire Blue Cross*	*Aetna*	*Empire Blue Cross*
Vision care					
Eye exam	100 per cent 1 exam every 12 months	100 per cent after $20 co-pay 1 exam every 12 months	100 per cent after $15 co-pay 1 exam every 12 months	80 per cent 1 exam every 12 months	$40 allowance 1 exam every 12 months
Frames and optical lenses	$45 every 24 months for frames and lenses from select group	$100 allowance, then savings of up to 35 per cent at participating centres	$130 allowance, then 20 per cent discount on remaining balance for frames, $10 co-pay for lenses	80 per cent up to $100 per year	$45 for frames $25/pair single vision $40/pair bifocal lenses $55/pair trifocal lenses (amounts listed are allowances provided by insurance)
Other benefits					
Physical and other inpatient therapy	100 per cent 90 visits	100 per cent	100 per cent 60 visits	80 per cent	80 per cent after deductible 60 visits
Physical and other outpatient therapy	100 per cent 90 visits	100 per cent	100 per cent after $20 co-pay 60 visits	80 per cent after deductible	80 per cent after deductible 60 visits
Durable medical equipment	100 per cent	100 per cent	100 per cent	80 per cent	Not covered

Annex III

Empire Blue Cross PPO

Plan outline

The Empire Blue Cross PPO plan provides worldwide coverage for hospitalization and surgical, medical, vision and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or out-of-network provider.

The present annex provides a high-level summary chart of the plan. For detailed information, staff members must review the Empire Blue Cross PPO plan description document available from the Health and Life Insurance Section website (www.un.org/insurance).

In addition, members of the Empire Blue Cross plan have access to UnitedHealthcare Global Assistance and Risk and ActiveHealth as part of their participation in the plan.

Coverage when travelling or living outside the United States is handled by Blue Cross Blue Shield Global Core. Details can be found in the Empire Blue Cross PPO plan description document.

Empire Blue Cross PPO summary of benefits

Benefits	*In-network*[a]	*Out-of-network*
Annual deductible		
Individual	$0	$250
Family	$0	$750
Insurance coverage (percentage at which the plan pays benefits)	100 per cent	80 per cent
Annual out-of-pocket maximum		
Individual	$0	$1,250
Family	$0	$3,750
		(includes annual deductible; network and prescription drug co-pays do not count towards the out-of-pocket limit)
Lifetime maximum	Unlimited	
Dependent children	Covered to end of calendar year in which child reaches age 25	
Claim submission	Provider files claims	You file claims

Benefits	*In-network*[a]	*Out-of-network*
Hospital services and related care coverage		
Inpatient[b]		
– Unlimited days — semi-private room and board – Hospital-provided services – Routine nursery care	100 per cent	80 per cent after deductible within the United States 100 per cent outside the United States
Outpatient		
– Surgery and ambulatory surgery[b] – Pre-surgical testing (performed within 7 days of scheduled surgery) – Blood – Chemotherapy and radiation therapy – Mammography screening and cervical cancer screening	100 per cent	80 per cent after deductible within the United States 100 per cent outside the United States
Mandatory pre-registration[b] **(1-800-982-8089)**	Pre-registrations are your responsibility	Pre-registrations are your responsibility
(For emergency admission, call within 48 hours or the next business day if admitted on a weekend)		
Hospital emergency room[c] **(initial visit)**		
– Accidental injury – Sudden and serious medical condition	100 per cent, including physician's charges, after $75 co-pay (waived if admitted within 24 hours)	100 per cent, including physician's charges, after $75 co-pay (waived if admitted within 24 hours)
Emergency room visit for non-emergency care is not covered		
Urgent care	100 per cent after $15/$20 co-pay	Subject to deductible and co-insurance
Ambulance	100 per cent up to the allowed amount	
Air ambulance (to nearest acute care hospital for emergency inpatient admissions)	100 per cent	
Home health care[b,d]		
– Up to 200 visits per calendar year	100 per cent	– 80 per cent after deductible within the United States – 100 per cent outside the United States
– Home infusion therapy	100 per cent	– Covered in-network only

Benefits	*In-network*[a]	*Out-of-network*
Outpatient kidney dialysis		
Home, hospital-based or free-standing facility treatment	100 per cent	80 per cent after deductible
Skilled nursing facility[b]		
Up to 120 days per calendar year	100 per cent	In-network only within the United States 80 per cent after deductible outside the United States
Hospice[b]		
Up to 210 days per lifetime	100 per cent	In-network only
Physician services and other medical benefits (excluding behavioural health and substance abuse care)		
Office/home visits/office consultations	100 per cent after $15/$20 primary care physician/specialist co-pay	80 per cent after deductible
Telemedicine (LiveHealth Online) covered in-network only	100 per cent after $15 primary care physician co-pay	80 per cent after deductible
Surgery	100 per cent	80 per cent after deductible
Surgical assistant	100 per cent	80 per cent after deductible
Anaesthesia	100 per cent	80 per cent after deductible
Inpatient visits/consultations	100 per cent	80 per cent after deductible
Maternity care	100 per cent after initial visit	80 per cent after deductible
Diagnostic X-rays	100 per cent	80 per cent after deductible
Laboratory tests	100 per cent	80 per cent after deductible
Chemotherapy and radiation therapy Hospital outpatient or physician's office	100 per cent	80 per cent after deductible
MRIs/MRAs, PET/CAT scans and nuclear cardiology scans[b]	100 per cent	80 per cent after deductible
Cardiac rehabilitation[b]	100 per cent after $20 specialist co-pay	80 per cent after deductible
Second surgical opinion[c]	100 per cent after $20 specialist co-pay	80 per cent after deductible
Second medical opinion for cancer diagnosis	100 per cent after $20 specialist co-pay	80 per cent after deductible[d]
Allergy testing and allergy treatment	100 per cent after $20 specialist co-pay per office visit for testing 100 per cent for treatment visits	80 per cent after deductible

Benefits	*In-network*[a]	*Out-of-network*
Prosthetic, orthotics, durable medical equipment[g]	100 per cent	In-network only
Medical supplies	100 per cent	100 per cent up to the allowed amount
Preventive care		
Annual physical exam	100 per cent after $15 co-pay	80 per cent after deductible
Diagnostic screening tests	100 per cent	80 per cent after deductible
Prostate specific antigen (PSA) test	100 per cent	80 per cent after deductible
Well-woman care	100 per cent after $15 co-pay	80 per cent after deductible
Mammography screening	100 per cent	80 per cent after deductible
Well-child care (including recommended immunizations)[d]		
– Under 1 year of age: 7 visits – 1-4 years old: 7 visits – 5-11 years old: 7 visits – 12-17 years old: 6 visits – 18 years to 19th birthday: 2 visits	100 per cent	100 per cent
Physical therapy and other skilled therapies		
Physical therapy[b]		
– 60 inpatient visits, and	100 per cent	80 per cent after deductible
– 60 visits combined in home, office or outpatient facility	100 per cent after $20 specialist co-pay	80 per cent after deductible Pre-certification not required for out-of-network
Occupational, speech, vision[b]		
60 visits combined in home, office or outpatient facility	100 per cent after $20 specialist co-pay	80 per cent after deductible
Behavioural health and substance abuse services[h]		
Inpatient mental health care	100 per cent	80 per cent after deductible
Outpatient mental health care	100 per cent (LiveHealth Online behavioural health) covered in-network only	80 per cent after deductible
Inpatient alcohol and substance abuse	100 per cent	80 per cent after deductible
Outpatient alcohol and substance abuse	100 per cent	80 per cent after deductible

Benefits	*In-network*[a]	*Out-of-network*
Prescription drug benefits		
Card programme 30-day supply (800) 342-9816	Generic: 20 per cent co-pay with $5 minimum and up to a maximum of $20 per prescription Brand name: 25 per cent co-pay up to a maximum of $30 per prescription	Within the United States: 60 per cent after deductible Outside the United States: 80 per cent after deductible (Express Scripts prescription drug claim form must be filed for reimbursement) The co-insurance will not count towards the $1,250/$3,750 out-of-pocket limit
Mail order (Express Scripts) — Fax: (877) 426-1097	100 per cent after $15 co-pay for up to a 90-day supply from participating mail order vendor	
Prescriptions for mail order programme: when a brand name drug is dispensed and an equivalent generic is available, the member will pay the $15 co-pay plus the difference in cost between the generic and the brand name drug unless the doctor specifies the brand name drug by writing "DAW" or "Dispense as written" on the prescription.		
In that event, you pay the normal $15 co-pay only		
Vision care programme		
Blue View Vision		
(866) 723-0515		
(Eye Med in New Jersey)		
Routine eye exam (once every 12 months)	$15 co-pay	$40 allowance
Eyeglass frames (once every 12 months)	$130 allowance, then 20 per cent off balance	$45 allowance
Eyeglass lenses		
Single	$10 co-pay, then covered in full	$25 allowance
Bifocal	$10 co-pay, then covered in full	$40 allowance
Trifocal	$10 co-pay, then covered in full	$55 allowance
Eyeglass lens upgrades		
UV coating	$15 member cost	$0
Tint (solid and gradient)	$15 member cost	$0
Standard scratch-resistance	$15 member cost	$0
Standard polycarbonate	$40 member cost	$0
Standard progressive	$65 member cost	$0
Standard anti-reflective coating	$45 member cost	$0
Other add-ons and services	20 per cent off retail price	$0

Benefits	*In-network*[a]	*Out-of-network*
Contact lenses		
Elective conventional	$130 allowance. then 15 per cent off balance	$105 allowance
Elective disposable	$130 allowance	$105 allowance
Non-elective	Covered in full	$210 allowance
Contact lens fitting		
Standard fitting	Up to $55	$0
Premium fitting	10 per cent off retail price	$0
In addition, Blue View Vision gives members 40 per cent off an additional pair of complete eyeglasses, 15 per cent off the retail price of conventional contact lenses, and 20 per cent off the retail price of eyewear accessories (some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases)		
Other health care		
Acupuncture	100 per cent after $20 co-pay	80 per cent after deductible
$1,000 annual limit on combined in- and out-of-network benefits		
Chiropractic care	100 per cent after $20 co-pay	80 per cent after deductible
$1,000 annual limit on combined in- and out-of-network benefits		
Hearing exam (every 3 years)	100 per cent after $20 specialist co-pay	80 per cent after deductible
Hearing appliance	100 per cent up to $750 maximum benefit per hearing device per ear every 3 years covered	80 per cent after deductible, up to $750 maximum benefit per hearing device per ear every 3 years

[a] In-network services (except mental health or alcohol/substance abuse) are those from a provider that participates with Empire or another Blue Cross Blue Shield plan through the BlueCard Programme, or a participating provider with another Blue Cross Blue Shield plan that does not have a PPO network and does accept a negotiated rate arrangement as payment in full.
[b] Medical Management Programme must pre-approve or benefits will be reduced by 50 per cent up to $2,500.
[c] If admitted, Medical Management must be called within 24 hours or as soon as reasonably possible.
[d] Combined maximum visits for in-network and out-of-network services.
[e] Charges to members do not apply if the second surgical opinion is arranged through the Medical Management Programme.
[f] If arranged through the Medical Management Programme, services provided by an out-of-network specialist will be covered as if the services had been in-network (i.e. subject to the in-network co-payment).
[g] In-network vendor must call Medical Management to pre-certify.
[h] Empire Behavioural Health Services must pre-approve or benefits will be reduced by 50 per cent up to $2,500. Out-of-network mental health care does not require pre-certification; however, outpatient alcohol and substance abuse visits must be pre-certified. In-network mental health services are those from providers that participate with Empire Behavioural Health Services.

Annex IV

Aetna Open Choice PPO/POS II

Plan outline

The Aetna Open Choice PPO/Aetna Choice POS II offers worldwide coverage for hospitalization and surgical, medical, vision and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or out-of-network provider.

The present annex provides a high-level summary chart of the plan. For detailed information, staff members must review the Aetna Open Choice PPO/POS II plan description document available from www.un.org/insurance.

In addition, members of the Aetna plan have access to UnitedHealthcare Global Assistance and Risk and ActiveHealth as part of their participation in the plan.

Aetna Open Choice PPO/POS II summary of benefits

Benefits	*In-network*	*Out-of-network*
Annual deductible		
Individual	$0	$250 for Aetna (domestic) only
Family	$0	$750 for Aetna (domestic) only
Insurance coverage (percentage at which the plan pays benefits)	100 per cent except where noted	100 per cent hospital; 80 per cent all other, except where noted
Annual out-of-pocket maximum		
Individual	$0	$1,500 for Aetna (domestic) $1,000 for Aetna International when using United States in-network providers
Family	$0	$4,500 for Aetna (domestic) $3,000 for Aetna International when using United States in-network providers (includes annual deductible; network and prescription drug co-pays do not count towards the out-of-pocket limit)
Lifetime maximum	Unlimited	Unlimited
Dependent children	Covered to end of calendar year in which child reaches age 25	
Claim submission	Provider files claims	You file claims
Hospital services and related care coverage		
Inpatient coverage	100 per cent	
Outpatient coverage	100 per cent	
Mandatory pre-registration (1-888-632-3862) Applies to inpatient hospital, skilled nursing facility, home health care, hospice care and private duty nursing care	Provider is responsible	You or provider are responsible
(For emergency admission, call within 48 hours or next business day if admitted on weekend)		
Hospital emergency room Based on symptoms, i.e. constituting a perceived life-threatening situation	100 per cent, including physician's charges, after $75 co-pay (waived if admitted within 24 hours)	100 per cent, including physician's charges, after $75 co-pay (waived if admitted within 24 hours)
Hospital emergency room For non-emergency care (examples of conditions: skin rash, earache, bronchitis, etc.)	80 per cent	80 per cent after deductible

Benefits	*In-network*	*Out-of-network*
Ambulance [there are no network providers for these services at the present time]	100 per cent	
Skilled nursing facility	100 per cent	
	Up to 365 days per year for restorative care as determined by medical necessity	
Private duty nursing (in-home only)	100 per cent, subject to yearly limits of $5,000 and 70 "shifts" as well as $10,000 lifetime	
	Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Pre-certification is strongly recommended	
Home health care	100 per cent	
Up to 200 visits per year	Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Pre-certification is strongly recommended	
Hospice (210 days)	100 per cent, deductible does not apply	
Plus 5 days bereavement counselling		
Physician services		
Office visits	100 per cent after $15/$20 primary care physician/specialist co-pay	80 per cent after deductible
For treatment of illness or injury		
(non-surgical)		
Telemedicine	100 per cent after $15 primary care physician co-pay	80 per cent after deductible
Maternity	100 per cent after $15 co-pay	80 per cent after deductible
(includes voluntary sterilization and voluntary abortion, see family planning)		
Physician in-hospital services	100 per cent	80 per cent after deductible
Other in-hospital physician services	100 per cent	80 per cent after deductible
(e.g. attending/independent physician who does not bill through hospital)		
Surgery (in hospital or office)	100 per cent	80 per cent after deductible
Second surgical opinion	100 per cent	100 per cent after deductible
Anaesthesia	100 per cent (if participating hospital)	80 per cent after deductible
Allergy testing and treatment	100 per cent after $20 specialist co-pay	80 per cent after deductible
(given by a physician)		
Allergy injections	100 per cent	80 per cent after deductible
(not given by a physician)		

Benefits	*In-network*	*Out-of-network*
Preventive care		
Routine physicals and immunizations – Children age 7+ and adults: 1 routine exam every 12 months	100 per cent after $15 co-pay	80 per cent after deductible
Well-child care and immunizations Well-child care to age 7: – 6 visits per year age 0-1 year – 2 visits per year age 1-2 years – 1 visit per year age 2-7 years	100 per cent	
Routine OB/GYN exam 1 routine exam per calendar year, including 1 Pap smear	100 per cent after $15 co-pay	80 per cent after deductible
Family planning		
– Office visits, including tests and counselling	100 per cent after $20 specialist co-pay	80 per cent after deductible
– Surgical sterilization procedures for vasectomy/tubal ligation (excludes reversals)	100 per cent	80 per cent (deductible waived)
Infertility treatment		
– Office visits, including testing and counselling	100 per cent after $20 specialist co-pay	80 per cent after deductible
– Artificial insemination limited to 6 treatments per lifetime	100 per cent	80 per cent after deductible
– Advanced reproductive technology limited to $25,000 per lifetime for medical expenses and $10,000 per lifetime for pharmacy expenses	100 per cent	80 per cent after deductible
Routine mammogram (no age limit)	100 per cent	80 per cent after deductible 100 per cent if performed on an inpatient basis or in the outpatient department of a hospital
Annual urological exam by urologist	100 per cent	80 per cent after deductible
Behavioural health and substance abuse services		
Mental health inpatient services (1-800-424-1601)	100 per cent	100 per cent after deductible

Benefits	*In-network*	*Out-of-network*
Inpatient coverage		
These services are provided by Aetna Behavioural Health. Pre-registration of inpatient confinements is required. For in-network services, the network provider is responsible for pre-registration. For out-of-network inpatient services, either the physician or the participant must pre-register the confinement		
Outpatient coverage	100 per cent	80 per cent after deductible
For out-of-network outpatient behavioural health and substance abuse benefits; the patient co-insurance does not count towards meeting the annual out-of-pocket limits		
Crisis intervention	100 per cent	80 per cent after deductible
Alcohol/drug abuse		
Inpatient coverage	100 per cent	100 per cent after deductible
Outpatient coverage	100 per cent	80 per cent after deductible
Prescription drug benefits		
Aetna Retail Rx (1-800-784-3991) **Aetna International Retail Rx (1-800-231-7729)** **Retail means regular 30-day supply**	Generic: 20 per cent co-pay with minimum of $5 and up to a maximum of $20 per prescription Brand name: 25 per cent co-pay up to a maximum of $30 per prescription	Within the United States: 60 per cent after deductible Outside the United States: 80 per cent after deductible The co-insurance will not count towards $1,250/$3,750 out-of-pocket limit
Aetna Mail Order Rx **(1-888-792-3862)** **Aetna International Mail Order Rx** **(1-800-231-7729)** **Mail order means 90-day supply**	100 per cent after $15 co-pay for up to a 90-day supply from participating mail order vendor	
Prescriptions for mail order programme: when a brand name drug is dispensed and an equivalent generic is available, the member will pay the $15 co-pay plus the difference in cost between the generic and the brand name drug unless the doctor specifies the brand name drug by writing "DAW" or "Dispense as written" on the prescription. In that event, you pay the normal $15 co-pay only		
Vision and hearing care		
Eye exam (once every 12 months)	100 per cent	80 per cent, deductible does not apply
Optical lenses (including contact lenses once every 12 months)	$100 maximum for lenses and frames purchased in a 12-month period	
Aetna Vision Discount Programme **(1-800-793-8616)** **Discount information for laser surgery (1-800-422-6600)**	Save up to 35 per cent on frames and about 15 per cent for non-disposable at participating EyeMed centres. Discounts available for laser surgery	

Benefits	*In-network*	*Out-of-network*
Hearing exam Evaluation and audiometric exam	100 per cent after $20 co-pay (1 exam every 3 years; exam must be performed by otolaryngologist or state-certified audiologist)	80 per cent after deductible (1 exam, limited to $100 reimbursement every 3 years; exam must be performed by otolaryngologist or state-certified audiologist)
Hearing device **[there are no network providers for these services at the present time]**	80 per cent, deductible does not apply; $750 maximum benefit per hearing device per ear every 3 years	
Other health care		
Physical and occupational therapy	100 per cent	80 per cent after deductible
Laboratory tests, diagnostic X-rays	100 per cent	80 per cent after deductible
Speech therapy	80 per cent after deductible for out-of-network services (where services are rendered by a participating provider, 100 per cent reimbursement applies after $20 co-pay)	
Outpatient diabetic self-management education programme	80 per cent, deductible does not apply If services are rendered in a hospital, 100 per cent reimbursement applies with no co-pay. If rendered in a network doctor's office, 100 per cent reimbursement with $20 specialist co-pay applies	
Durable medical equipment	80 per cent, deductible does not apply If services are rendered by a network provider or within a hospital setting, 100 per cent reimbursement applies with no co-pay	
Acupuncture	100 per cent after $20 co-pay up to a maximum benefit of $1,000/year	80 per cent after deductible up to a maximum benefit of $1,000/year
	In-network and out-of-network benefits are combined for a maximum of $1,000 per calendar year	
Chiropractic care	100 per cent after $20 co-pay up to a maximum benefit of $1,000/year	80 per cent after deductible up to a maximum benefit of $1,000/year
	In-network and out-of-network benefits are combined for a maximum of $1,000 per calendar year	

Benefits	*Aetna Vision Discount discounted fee*
Frames	
Priced up to $60.99 retail	35 per cent off retail
Priced from $61.00 to $80.99 retail	35 per cent off retail
Priced from $81.00 to $100.99 retail	35 per cent off retail
Priced from $101.00 and up	35 per cent off retail
Lenses: per pair (uncoated plastic)	
Single vision	$40
Bifocal	$60
Trifocal	$80
Standard progressive (no-line bifocal)	$120
Lens options: per pair (add to lens prices above)	
Polycarbonate	$40
Scratch-resistant coating	$15
Ultraviolet coating	$15
Solid or gradient tint	$15
Glass	20 per cent off retail
Photochromic	20 per cent off retail
Anti-reflective coating	$45

Annex V

HIP Health Plan of New York

Plan outline

The HIP plan is an HMO and follows the concept of total prepaid group practice hospital and medical care. This means that there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the greater New York area.

In addition, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP participating pharmacies and are prescribed by HIP physicians or any physician in a covered emergency.

The present annex provides a high-level summary chart of the plan. For detailed information, staff members must review the HIP Health Plan of New York plan description document available from www.un.org/insurance.

As from 1 July 2013, the HIP plan is closed to new subscribers (i.e. staff members or retirees). Subscribers who are currently covered may remain in the plan, and any changes related to eligible household members will be accepted. However, a current subscriber who transfers to another United States plan during the 2017 annual campaign will not be allowed to return to the HIP plan in future annual campaigns.

HIP Health Plan of New York summary of benefits

Benefits	*Coverage*
Hospital services and related care	
Inpatient	100 per cent
– Unlimited days: semi-private room and board	
– Hospital-provided services	
– Routine nursing care	
Outpatient	100 per cent
– Surgery and ambulatory surgery	
– Pre-surgical testing (performed within 7 days of scheduled surgery)	
– Chemotherapy and radiation therapy	
– Mammography screening and cervical cancer screening	
Emergency room/facility (initial visit)	100 per cent
– Accidental injury	
– Sudden and serious medical condition	
Ambulance	100 per cent
Home health care	
– Up to 200 visits per calendar year	100 per cent
– Home infusion therapy	100 per cent
Outpatient kidney dialysis	
Home, hospital-based or free-standing facility treatment	100 per cent after $10 co-pay
Skilled nursing facility	
Unlimited days per calendar year	100 per cent
Hospice	
Up to 210 days per lifetime	100 per cent
Physician services	
Office or home visits/office consultations	100 per cent
Surgery	100 per cent
Surgical assistant	100 per cent
Anaesthesia	100 per cent
Inpatient visits/consultations	100 per cent
Maternity care	100 per cent
Artificial insemination/unlimited procedures based on New York State mandate	100 per cent

Benefits		*Coverage*
Diagnostic X-rays, MRI, CAT scans		100 per cent
Laboratory tests		100 per cent
Inpatient hospital private duty nursing		100 per cent
Cardiac rehabilitation		100 per cent
Second surgical opinion		100 per cent
Second medical opinion for cancer diagnosis		100 per cent
Allergy testing and allergy treatment		100 per cent
Prosthetic, orthotic and durable medical equipment		100 per cent
Medical supplies		100 per cent
Preventive care		
Annual physical exam		100 per cent
Diagnostic screening test		100 per cent
Prostate specific antigen (PSA) test		100 per cent
Well-woman care (no referral needed)		100 per cent
Mammography screening/Pap smears		100 per cent
Well-child care (including recommended immunizations)		100 per cent
– Newborn baby	1 in-hospital exam at birth	
– Birth to 1 year of age	6 visits	
– 1-2 years of age	3 visits	
– 3-6 years of age	4 visits	
– 7 years up to 19th birthday	6 visits	
Physical therapy and other skilled therapies		
Physical therapy		
Up to 90 inpatient days per calendar year		100 per cent
Physical therapy (benefit combined with occupational, respiratory and speech)		
– 90 inpatient visits		100 per cent
– 90 outpatient visits		100 per cent
Occupational, respiratory, speech (benefit combined with physical therapy)		
– 90 inpatient visits		100 per cent
– 90 outpatient visits		100 per cent

Benefits	*Coverage*
Behavioural health and substance abuse services	
Mental health care	100 per cent
Outpatient alcohol and substance abuse	100 per cent
Inpatient alcohol and substance abuse/rehab	100 per cent
Prescription drug benefits	
Pharmacy	100 per cent after $5 co-pay for generic/brand, 30-day supply
Mail order programme	100 per cent after $2.50 co-pay for generic/brand, 30-day supply
Vision care programme	
Through a designated group of providers	100 per cent for 1 exam every 12 months
	100 per cent after $35 co-pay for standard corrective lenses and $80 allowance for one pair standard frames from a select group every 24 months
Other health care	
Acupuncture/yoga/massage	Discounted rates
Chiropractic care (no referral needed)	100 per cent

Annex VI

Cigna US Dental PPO

Plan outline

The dental PPO programme offers a large network of participating providers in the greater New York metropolitan area and nationally. A dental PPO functions like a medical PPO: the network of dentists who participate in the Cigna US Dental PPO plan accept as payment a fee schedule negotiated with Cigna. When covered services are rendered by an in-network provider, Cigna reimburses the dentist according to the schedule and the participant normally has no out-of-pocket expense.

The present annex provides a high-level summary chart of the plan. For detailed information, subscribers must review the Cigna US Dental PPO plan description document available from www.un.org/insurance.

Cigna US Dental PPO summary of benefits

Benefits	*In-network*	*Out-of-network*
Plan year maximum — 1 July 2016-30 June 2017 (Class I, II and III expenses)	Year 1: $2,250	Year 1: $2,250
	Year 2: $2,350	Year 2: $2,350
	Year 3: $2,450	Year 3: $2,450
	Year 4: $2,550	Year 4: $2,550
Maximum amounts in years 2-4 are dependent on Class I services being rendered		
Plan year deductible — 1 July 2016-30 June 2017	$0	$50 per person
		$150 per family
Reimbursement levels	Based on reduced contracted fees	Based on reasonable and customary allowances

	Plan pays	*You pay*	*Plan pays*	*You pay*
Class I — Preventive and diagnostic care	100 per cent	No charge	90 per cent	10 per cent
Oral exams/routine cleanings				
Full mouth X-rays				
Bitewing X-rays				
Panoramic X-rays				
Periapical X-rays				
Fluoride application				
Sealants space maintainers				
Emergency care to relieve pain				
Histopathologic exams				
Class II — Basic restorative care	100 per cent	0 per cent	80 per cent	20 per cent
Fillings/root canal therapy/endodontics				
Osseous surgery				
Periodontal scaling and root planning				
Denture adjustments and repairs				
Oral surgery — simple extractions				
Oral surgery — all except simple extractions				
Anaesthetics: surgical extractions of impacted teeth				
Repairs to bridges, crowns and inlays				
Class III — Major restorative care	100 per cent	0 per cent	80 per cent	20 per cent
Crowns				
Surgical implants				
Dentures				
Bridges inlays/onlays				
Prosthesis over implant				
Class IV — Orthodontia lifetime maximum	100 per cent $2,250 dependent children up to age 19	0 per cent	70 per cent $2,250 dependent children up to age 19	30 per cent

(Note on following page)

(Note to table)

Note: This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in the insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company. Cigna Dental refers to the following operating subsidiaries of Cigna Corporation: Connecticut General Life Insurance Company, and Cigna Dental Health, Inc., and its operating subsidiaries and affiliates. The Cigna Dental Care plan is provided by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc. and Cigna Dental Health of Virginia, Inc. In other states, the Cigna Dental Care plan is underwritten by Connecticut General Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrolee, including, but not limited to, prepaid plans, managed care plans and plans with open access features. The Cigna Dental PPO is underwritten and/or administered by Connecticut General Life Insurance Company, with network management services provided by Cigna Dental Health, Inc. For Arizona/Louisiana residents the dental PPO plan is known as CG Dental PPO. In Texas, Cigna Dental's network-based indemnity plan is known as Cigna Dental Choice. The Cigna Dental Traditional plan is underwritten or administered by Connecticut General Life Insurance Company. In Arizona and Louisiana, the Cigna Dental Traditional plan is referred to as CG Traditional.

Annex VII

UnitedHealthcare Global Assistance and Risk

UnitedHealthcare Global Assistance and Risk is a service available to Aetna and Empire Blue Cross subscribers. The 2017 monthly cost per subscriber is $0.22 and is built into the premium schedule for Aetna and Empire Blue Cross as set out in annex I of the present information circular.

UnitedHealthcare Global Assistance and Risk is a programme providing emergency medical assistance management, including coordinating emergency evacuation and repatriation, and other travel assistance services when the staff member is 100 or more miles from home. Below is a summary of the management coordination services provided.

Medical assistance services

Worldwide referrals: Worldwide medical and dental referrals are provided to help the participant to locate appropriate treatment or care.

Monitoring of treatment: UnitedHealthcare Global Assistance and Risk coordinators will continually monitor the participant's case and UnitedHealthcare Global Assistance and Risk physician advisers will provide the participant with consultative and advisory services, including the review and analysis of the quality of medical care being received.

Facilitation of hospital payment: Upon securing payment or a guarantee to reimburse, UnitedHealthcare Global Assistance and Risk will either wire funds or guarantee the required emergency hospital admittance deposits.

Transfer of insurance information to medical providers: UnitedHealthcare Global Assistance and Risk will assist the participant with hospital admission, such as relaying insurance benefit information, to help to prevent delays or denials of medical care. UnitedHealthcare Global Assistance and Risk will also assist with discharge planning.

Medication and vaccine transfers: In the event medication or vaccine products are not available locally, or a prescription medication is lost or stolen, UnitedHealthcare Global Assistance and Risk will coordinate their transfer to the participant upon the prescribing physician's authorization, if it is legally permissible.

Replacement of corrective lenses and medical devices: UnitedHealthcare Global Assistance and Risk will coordinate the replacement of corrective lenses or medical devices if they are lost, stolen or broken during travel.

Dispatch of doctors/specialists: In an emergency where the participant cannot adequately be assessed by telephone for possible evacuation, or cannot be moved, and local treatment is unavailable, UnitedHealthcare Global Assistance and Risk will send an appropriate medical practitioner to the participant.

Medical records transfer: Upon the participant's consent, UnitedHealthcare Global Assistance and Risk will assist with the transfer of medical information and records to the participant or to the treating physician.

Continuous updates to family, employer and physician: With the participant's approval, UnitedHealthcare Global Assistance and Risk will provide case updates to appropriate individuals designated in order to keep family, employer and physicians informed.

Hotel arrangements for convalescence: UnitedHealthcare Global Assistance and Risk will assist with the arrangement of hotel stays and room requirements before and after hospitalization.

The following services do not fall within the purview of health insurance but are, nevertheless, included in the monthly UnitedHealthcare Global Assistance and Risk fee paid by participants in the Aetna and Empire Blue Cross plans.

Travel assistance services

Emergency travel arrangements: UnitedHealthcare Global Assistance and Risk will make new reservations for airlines, hotels and other travel services in the event of an illness or injury.

Transfer of funds: UnitedHealthcare Global Assistance and Risk will provide an emergency cash advance subject to UnitedHealthcare Global Assistance and Risk first securing funds from the participant or participants.

Replacement of lost or stolen travel documents: UnitedHealthcare Global Assistance and Risk will assist in taking the necessary steps to replace passports, tickets and other important travel documents.

Legal referrals: Should legal assistance be required, UnitedHealthcare Global Assistance and Risk will direct the participant to an attorney who will assist in securing a bail bond.

Interpretation services: UnitedHealthcare Global Assistance and Risk's multilingual assistance coordinators are available to provide immediate verbal interpretation assistance in a variety of languages in an emergency; otherwise, UnitedHealthcare Global Assistance and Risk will provide referrals to local interpreter services.

Message transmittals: The participant may send and receive emergency messages toll-free, 24 hours a day, through the UnitedHealthcare Global Assistance and Risk emergency response centre.

Online services

Global Intelligence Centre: Participants have access to the UnitedHealthcare Global Assistance and Risk member centre, which includes detailed information on the UnitedHealthcare Global Assistance and Risk programme, as well as medical and security information for more than 230 countries and territories around the world. To activate the member centre account:

1. Visit https://members.uhcglobal.com.
2. In the login box, select "create user".
3. Enter the UnitedHealthcare Global Assistance and Risk ID number for the United Nations (33211).
4. Accept the user agreement.
5. Enter in your personal account information to designate yourself a unique username and password.

Medical Intelligence Reports: The participant will have online access to continuous updates on health information pertinent to your destination(s) of travel, such as immunizations, vaccinations, regional health concerns, entry and exit requirements and transportation information. Risk ratings are provided for each country ranking the severity of the risk concerning disease, quality of care, access to care and cultural challenges.

World Watch® global security intelligence: The participant will have online access to the latest authoritative information and security guidance for over 170 countries and 280 cities. Information includes the latest news, alerts, risk ratings and a broad array of destination information, including crime, terrorism, local hospitals, emergency phone numbers, culture, weather, transportation information, entry and exit requirements and currency.

The UnitedHealthcare Global Assistance and Risk global security and medical databases are continuously updated and include intelligence from thousands of worldwide sources. This information is also available upon request by calling the UnitedHealthcare Global Assistance and Risk emergency response centre.

Custom travel reports: Using the Medical Intelligence Reports and World Watch® online intelligence tools, the participant is able to create customized, printable health and security profiles by destination.

Hotspots travel alerts: Subscribe through the member centre to receive a free weekday email snapshot of security events from around the world. This bulletin provides a quick review of events, listed by region and destination, that could have a significant impact on travellers. Each event summary includes country threat levels and significant dates.

Conditions and limitations

The services described above are available to the participant only during the participant's enrolment period and only when the participant is 100 or more miles away from his or her residence.

How to use UnitedHealthcare Global Assistance and Risk access services 24 hours a day, 7 days a week, 365 days a year

If participants have a medical problem, they should call the toll-free number of the country in which they are located (see list below), or call collect the 24-hour UnitedHealthcare Global Assistance and Risk emergency response centre in Baltimore, Maryland:

Phone: +1-410-453-6330

Website: www.uhcglobal.com

Email: Assistance@uhcglobal.com

A multilingual assistance coordinator will ask for your name, your company or group name, the United Nations UnitedHealthcare Global Assistance and Risk ID number (33211) and a description of your situation.

If the condition is an emergency, go immediately to the nearest physician or hospital without delay and then contact the UnitedHealthcare Global Assistance and Risk emergency response centre. It will then take the appropriate action to provide assistance and monitor care.

International toll-free telephone access numbers

Listed below are the telephone numbers for the worldwide UnitedHealthcare Global Assistance and Risk network. If you have a medical or travel problem, call UnitedHealthcare Global Assistance and Risk. Printed on your ID card are the telephone numbers for the worldwide UnitedHealthcare Global Assistance and Risk network. Call the toll-free number for the country in which you are located if one is available. If you are in a country that is not listed, or if the call will not go through, please call the Baltimore, Maryland, coordination centre collect. Be prepared to give

UnitedHealthcare Global Assistance and Risk your name, identification number, the name of the organization and a brief description of your problem.

Australia, including Tasmania	1-800-127-907
Austria	0-800-29-5810
Belgium	0800-1-7759
Brazil	0800-891-2734
China (northern)[a]	108888 (wait for tone) 800-527-0218
China (southern)[a]	10811 (wait for tone) 800-527-0218
Dominican Republic	1-888-567-0977
Egypt (inside Cairo)[a]	2-510-0200 (wait for tone) 877-569-4151
Egypt (outside Cairo)[a]	022-510-0200 (wait for tone) 877-569-4151
Finland	0800-114402
France and Monaco	0800-90-8505
Germany	0800 1 811401
Greece	00-800-4412-8821
Hong Kong, China	800-96-4421
Indonesia	001-803-1471-0621
Ireland	1-800-409-529
Israel	1-809-41-0172
Italy, Vatican City and San Marino	800-877-204
Japan	00531-11-4065
Mexico	001-800-101-0061
Netherlands	0800-022-8662
New Zealand	0800-44-4053
Philippines	1-800-1-111-0503
Portugal	800-84-4266
Republic of Korea	00798-1-1-004-7101
Singapore	800-1100-452
South Africa	0800-9-92379
Spain and Majorca	900-98-4467
Switzerland and Liechtenstein	0800-55-6029
Thailand	001-800-11-471-0661

[a] Indicates that the caller should dial the first portion of the phone number, wait for the tone and then dial the remaining numbers.

Turkey	00-800-4491-4834
United Kingdom of Great Britain and Northern Ireland, Isle of Jersey, the Channel Isles and Isle of Man	0800-252-074
United States of America, Canada, Puerto Rico, United States Virgin Islands, Bermuda	1-800-527-0218

UnitedHealthcare Global Assistance and Risk assistance coordination centre

(call collect)

United States: Baltimore, Maryland	1-410-453-6330

Notes:

When a toll-free number is not available, travellers are encouraged to call UnitedHealthcare Global Assistance and Risk collect. The toll-free numbers listed are available only when physically calling from within the country. We strongly encourage you to note this in your printed material to avoid confusion.

The toll-free Israel line is not available from payphones and there is a local access charge.

The toll-free Italy, Vatican City and San Marino number has a local charge for access.

In Italy, operator-assisted calls can be made by dialling 170. This will give you access to the international operator.

The toll-free Japan line is available only from touchtone phones (including payphones) equipped for international dialling.

If calling from Mexico on a payphone, the payphone must be a La Date payphone.

When calling the phone numbers in China, please dial as follows:

Northern regions — first dial 10888, then wait a second to be connected. After being connected, dial the remaining numbers.

Southern regions — first dial 10811, then wait a second to be connected. After being connected, dial the remaining numbers.

When calling the phone numbers in Egypt, please dial as follows:

Inside Cairo — first dial 510-0200, then wait a second to be connected. After being connected, dial the remaining numbers.

Outside Cairo — first dial 02-510-0200, then wait a second to be connected. After being connected, dial the remaining numbers.

International callers who are unable to place toll-free calls to UnitedHealthcare Global Assistance and Risk

Many telephone service providers, such as cell phones, payphones and other commercial phone venues, charge for, or outright bar, toll-free calls on their networks. In this case, callers should be instructed to try calling collect. If that is not an option, they will need to dial the UnitedHealthcare Global Assistance and Risk number directly and provide a number to which UnitedHealthcare Global Assistance and Risk may immediately call back.

Annex VIII

ActiveHealth wellness programme

The ActiveHealth programme was implemented in December 2008 as a health management service that provides confidential condition management and wellness programmes to Aetna and Empire Blue Cross health insurance plan participants. Condition management and wellness programmes work to reduce preventable conditions which are often precursors to more serious and chronic conditions. ActiveHealth provides important notifications known as "Health Actions" to participants and their doctors and assists in managing the health concerns of participants through the services noted below. Staff members may be contacted by ActiveHealth or can elect to participate in this programme through self-referral by calling ActiveHealth at 1-800-778-8351 or by enrolling at www.myactivehealth.com/unitednations.

- CareEngine and Health Actions: personalized and confidential communications to patients and physicians to improve the quality of care
- Nurse care programme: nurse coaching for members with chronic conditions
- MyActiveHealth: personal health website
- 24-hour informed nurse health line

CareEngine and Health Actions

ActiveHealth is "powered" by the CareEngine system that applies thousands of evidence-based clinical rules to aggregated member medical, pharmacy and laboratory claims along with self-reported data to uncover potential errors and instances of suboptimal care. The rules are applied on a continuous basis to all members of a covered population to find clinical improvement opportunities. For each potential opportunity identified, a Health Action is generated that identifies the clinical issue(s) found, and suggests a change in treatment that the evidence-based literature and treatment guidelines indicate would improve the patient's care. These Health Actions are communicated to treating physicians each time a potential health improvement opportunity is identified by the CareEngine system. Since the physician may have information about the patient that is not available to ActiveHealth, the decision of whether to implement a Health Action is up to the physician.

Nurse care programme

Members participating in the condition management programme are assigned to a nurse care manager who acts as their "personal health coach" around their specific conditions. The nurse care manager provides one-on-one education and support to the member in understanding his or her health needs and how best to leverage physician visits through informed communication.

Condition management provides comprehensive support for more than 30 chronic conditions that:

- Focuses on both physicians and patients in effecting behaviour changes leading to improved clinical and financial outcomes.
- Identifies and targets impactable clinical issues that are communicated to physicians and patients with specific actions that can be taken to improve patient care.

- Customizes member engagement and education activities and intensity according to the member's specific clinical issues and medical need.
- Creates a strong value proposition in that it targets resources to those members most likely to benefit from condition management interventions.
- Designs interventions and plans of care around the member's complete set of conditions and co-morbidities in order to maximize care and anticipate potentially harmful interactions between condition states.

The following is a list of nearly 40 chronic conditions included in the ActiveHealth nurse care programme:

Vascular

- Peripheral artery disease
- Cerebrovascular disease/stroke
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Hypertension — adult and paediatrics
- Hyperlipidaemia hypercoagulable state (blood clots)
- Heart failure

Diabetes — adult and paediatrics

Pulmonary

- Asthma — adult and paediatrics
- Chronic obstructive pulmonary disease (COPD)

Orthopaedic/rheumatologic

- Rheumatoid arthritis (RA)
- Osteoporosis
- Osteoarthritis (OA)
- Chronic back/neck pain
- Systemic lupus erythematosus

Gastrointestinal

- Gastroesophageal reflux disease (GERD)
- Chronic hepatitis B or C
- Peptic ulcer disease
- Inflammatory bowel disease (Crohn's disease and ulcerative colitis)

Neurologic conditions

- Seizure disorders
- Migraines
- Parkinson's disease

Geriatrics

Cancer

- Cancer (general)
- Breast cancer
- Lung cancer
- Lymphoma/leukaemia
- Prostate cancer
- Colorectal cancer

Renal

- Chronic kidney disease
- End stage renal disease

Other

- Cystic fibrosis — adult and paediatrics
- HIV
- Sickle cell disease — adult and paediatrics
- Weight management (obesity) — adult and paediatrics

MyActiveHealth: personal health website

MyActiveHealth is a simple yet powerful online platform that identifies health improvement opportunities in care and provides the tools and resources, such as digital coaching, to address them. It also identifies prescriptions and over-the-counter drugs that should not be mixed and provides alerts to alternative treatment opportunities to you and your family. MyActiveHealth allows you to:

- Store and easily retrieve information about doctor's visits, prescriptions, test results, immunizations and even family medical history.
- Access to your medical files securely anywhere the Internet is available — at home, at work, or even in the doctor's office.

- Share information with doctors, family members or caregivers by either printing out the records or granting online access.
- Provide doctors with a more complete picture of your health (if you choose to share it), and promotes better interaction with your doctor.
- Give each family member his or her own personal record to help keep things organized.
- Access easy-to-use tips, tools and trackers.
- Access personalized action items, reminders, recommended digital coach modules, a health assessment, health resource links and much more.

Access the MyActiveHealth website at www.myactivehealth.com/unitednations on your computer or mobile device.

24-hour informed health line

- 24/7 telephone access to registered nurses by calling 1-800-556-1555.
- Audio library on thousands of health topics such as common conditions/diseases, gender/age-specific issues, dental care, mental health, weight loss and much more!
- IHL nurses will work in tandem with the disease management programme as well as other coverages the United Nations has in place and will make referrals when appropriate.

Annex IX

UN Worldwide Plan

Plan benefits summary

The UN Worldwide Plan, administered by Cigna International Health Benefits, indemnifies members, within the limits of the plan, for reasonable and customary charges in respect of medical, hospital and dental treatment for illness, an accident or maternity. The aggregate reimbursement in respect of the total expenses covered by the plan that are incurred by an insured participant shall not exceed $250,000 in any calendar year. The provisions set forth below shall be subject to this limitation. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure, supplies or other services may also apply, depending on the type of service.

The present annex provides a high-level summary chart of the plan. For detailed information staff members must review the UN Worldwide Plan description document available from www.un.org/insurance or access the UN Worldwide Plan's website (www.cignahealthbenefits.com).

General cover — outpatient expenses

	Basic Medical Insurance Plan (BMIP)	*BMIP + Major Medical Benefits Plan (MMBP)*
Doctors' fees (GP) Paramedical fees Pharmacy Laboratory and medical imaging Mental health	80 per cent (see below for restrictions for services received in the United States)	96 per cent (yearly out of pocket of $200 per person per calendar year or $600 per family per calendar year for services received outside the United States)
Outpatient costs in the United States except for tele-psychiatry treatments (please see below for chemotherapy, haemodialysis and radiological treatments)	80 per cent (yearly deductible of $5,000 per person per calendar year or $15,000 per family per calendar year)	No MMBP

Note: Some treatments are subject to prior approval. Please refer to the detailed summary plan description on www.cignahealthbenefits.com for more information.

Specific treatments

	Benefits	*Remarks*
Chemotherapy	100 per cent	Doctors' fees at 80 per cent plus MMBP
Radiotherapy	100 per cent	Doctors' fees at 80 per cent plus MMBP
Haemodialysis	100 per cent	Doctors' fees at 80 per cent plus MMBP
Fertility treatments (in vitro fertilization not covered)	100 per cent	Doctors' fees at 80 per cent plus MMBP

Note: For chemo and radiotherapy and haemodialysis received in the United States, benefits are subject to prior approval (see below), and failure to comply will result in a penalty.

General cover — hospitalizations (subject to prior approval)

	Benefits	*Remarks*
Bed and board	100 per cent up to a maximum per day	The maximum per day varies depending on the region Cover restricted to 100 per cent of a semi-private room or ward for specific areas See details in the plan description on our website
Other hospital expenses	100 per cent	
Doctors' fees	80 per cent plus MMBP	
Personal expenses	Not covered	

Covered expenses incurred in the United States of America

	Benefits	*Remarks*
Increased deductible	$5,000 per person per calendar year or $15,000 per family per calendar year, except for tele-psychiatry which falls under the regular $200/$600 individual/family deductible	No BMIP or MMBP, except for tele-psychiatry which has a $200/$600 individual/family deductible
Strict enforcement of prior approval for: – Planned hospitalization – Selected outpatient treatments (chemo and radiotherapy, haemodialysis)	80 per cent (yearly deductible of $5,000 per person per calendar year or $15,000 per family per calendar year)	No MMBP

For more information, please check the website.

General cover — benefits with ceilings

	Benefits	*Ceiling*
Dental	80 per cent	– $1,000 per person per calendar year – carry over from previous year's balance
Optical	80 per cent	$250 per period of 24 months (counted as of date of purchase)
Medical check-up	100 per cent	$750 per person per calendar year
Home hospitalization	100 per cent	$5,000 per illness

Exclusions

- Insured participants who are mobilized or who volunteer for medical service in time of war
- Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered)

- Non-medical expenses, including spa cures, rejuvenation cures or cosmetic treatment (reconstructive surgery is covered where it is necessary as the result of an accident for which coverage is provided)
- Costs exceeding the reasonable and customary limit for the area in which they are incurred
- Preventive care, other than medical check-up and certain vaccinations
- Costs of travel or transportation (except to first hospital in case of emergency)
- In vitro fertilization
- Medical care that is not medically necessary
- Medical care that is not medically recognized as a treatment for the diagnosis provided
- Long-term care
- Products whose effectiveness has not been sufficiently proved scientifically and which are not generally medically recognized in the medical world (e.g. products containing glucosamine or chondroitin sulphate)
- Elective surgery not resulting from illness, an accident or maternity

Annex X

Provider contact directory

Websites

Online provider directories	*Instructions*
1. Aetna (domestic)	www.aetna.com/docfind/index.html
Aetna International (active staff at duty stations and retirees residing outside of the United States)	https://www.aetnainternational.com/members/login.do (a) Log in using your member ID and password (b) Click on "find healthcare" link on the left of your screen (c) Click on the destination of your choice (d) Begin search
2. Empire Blue Cross	https://www.empireblue.com/health-insurance/provider-directory/searchcriteria
Global Core Services	http://bcbsglobalcore.com (a) Accept terms and conditions of site use agreement (b) Type in YLD in the cell below the agreement (c) Click "Login"
3. HIP (Emblem) Health Plan of New York	http://www.emblemhealth.com/find-a-doctor
4. Cigna Dental	http://www.cigna.com/web/public/hcpdirectory
5. UN Worldwide Plan	http://www.cignahealthbenefits.com (a) Log in using your personal reference number and password (b) Click on "provider search"

Note: Staff members are strongly encouraged to establish usernames and passwords to access the member websites of the insurance carriers to obtain information on the status of claims, view benefits, request identification cards and print temporary identification cards, among others.

Addresses and telephone numbers of United States-based insurance carriers for claims and benefit enquiries

I. Aetna PPO/POS II	Aetna Inc. P.O. Box 981106 El Paso, TX 79998-1106
Tel.: (800) 784-3991	Member services (benefit/claim questions)
Tel.: (800) 333-4432	Pre-registration of hospital/institutional services
Tel.: (800) 872-3862	Aetna PPO/POS II members on travel
Tel.: (800) 784-3991	Participating pharmacy referral
Tel.: (888) 792-3862	Aetna Rx Home Delivery (mail order drugs) P.O. Box 417019, Kansas City, MO 64179-9892
Tel.: (888) 792-3862	Maintenance drug automated refills (credit card)

Tel.: (800) 424-1601	Aetna Behavioral Health
Tel.: (800) 793-8616	Vision One
Tel.: (800) 422-6600	Discount information on Lasik surgery
II. Aetna International PPO	Aetna International/Aetna P.O. Box 981543 El Paso, TX 79998-1543 USA
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside the United States)	Member services (benefit/claim questions)
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside the United States)	Pre-registration of hospital/institutional services
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside the United States)	Participating pharmacy referral
Other numbers	Same as for Aetna PPO/POS II above
III. Empire Blue Cross PPO	Empire Blue Cross Blue Shield PPO Member Services P.O. Box 1407 Church Street Station New York, NY 10008-1407
Tel.: (855) 519-9537	Member services (benefit/claim questions)
Tel.: (855) 519-9537	Medical Management Programme (pre-certification for hospital admissions, elective surgery, home care, skilled nursing facilities, second opinion referrals)
Tel.: (855) 519-9537	Empire Behavioral Health Services (prior approval of mental health/substance abuse care)
Tel.: (888) 613-6091	Empire Pharmacy Management Programme/Express Scripts (prescription card programme and pharmacy network and maintenance drug mail order drug information)
IV. Empire Blue Cross (international benefits and claims)	Global Core Service Center, P.O. Box 2048 — Southeastern, PA 19399 or claims@bcbsglobalcore.com
Tel.: 1-855-327-1444 1-312-935-1721 (call collect from outside the United States)	Global Core Services (international benefits and claims services)
Tel.: 1-866-723-0515	Blue View Vision Attn: Out Of Network (OON) Claims P.O. Box 8504 Mason, OH 45040

V. HIP	HIP Member Services Department 7 West 34th Street New York, NY 10001
Tel.: (800) HIP-TALK {(800) 447-8255}	HIP Member Services Dept. (walk-in service available) 6 West 35th Street New York, NY 10001
Tel.: (888) 447-4833	Hearing-/speech-impaired
Tel.: (877) 774-7693	Chiropractor hotline
Tel.: (888) 447-2526	Mental health hotline
Tel.: (800) 290-0523	Dental hotline
Tel.: (800) 743-1170	Lasik surgery (Davis Vision) hotline
VI. Cigna US Dental PPO plan	Cigna Dental P.O. Box 188037 Chattanooga, TN 37422-8037
Tel.: (800) 747-UNUN or (800) 747-8686	Claim submission, identification card requests and customer service
Tel.: (888) DENTAL8 or (888) 336-8258	For participating provider referrals
VII. UnitedHealthcare Global Assistance and Risk	UnitedHealthcare Global Assistance and Risk Assistance Corporation P.O. Box 19056 Baltimore, MD 21284
Tel.: (800) 527-0218	Within the United States
Tel.: (410) 453-6330 (call collect outside the United States)	UnitedHealthcare Global Assistance and Risk emergency response centre, Baltimore, MD
International toll-free access numbers	See detailed listing contained in annex VII
VIII. ActiveHealth	ActiveHealth Management 1333 Broadway New York, NY 10018
Tel.: (212) 651-8200	Corporate headquarters
Tel.: (800) 778-8351	ActiveHealth nurse care manager programme
Tel.: (800) 556-1555	24 Hour nurse line
www.myactivehealth.com/unitednations	MyActiveHealth website

IX. UN Worldwide Plan

You can reach customer service for Cigna 24 hours a day, 7 days a week, 365 days a year. In case of emergency or if you simply have a question, you can contact Cigna's multilingual staff in several ways. The contact details are also mentioned on your personal web pages and on your membership card.

	Antwerp office	Kuala Lumpur office	Miami office
	www.cignahealthbenefits.com		
	For claims: un.wwp@cigna.com For membership: clientservice1@cigna.com		
	+ 32 3 217 68 42	+ 60 3 2178 05 55	+ 1 305 908 91 01
	Cigna P.O. Box 69 2140 Antwerpen Belgium	Cigna P.O. Box 10612 50718 Kuala Lumpur Malaysia	Cigna P.O. Box 260790 33126 Miami, FL USA

Toll-free numbers

Wherever feasible, you can call Cigna for free through a toll-free number. If there is no toll-free number available for your country of stay, you can use the United Nations-dedicated phone number, which is also mentioned on your membership card. You can find the full list of available toll-free numbers per country on your personal web page.

Disclaimer: This circular provides only a summary of the benefits covered under the United Nations Headquarters insurance programme. Detailed benefit descriptions can be obtained from the website of the Health and Life Insurance Section.

Annex XI

Basic responsibilities of plan enrollees

In an effort to assist staff members, retirees and dependants covered under insurance administered by the United Nations, the present annex provides a helpful list of several key basic responsibilities relating to insurance. While the list is not exhaustive, it should be useful to remind each covered staff member, retiree and dependant of his or her basic responsibilities. The list is broken down into three primary categories:

(a) Plan enrolment;

(b) Plan knowledge;

(c) Fraud prevention.

Plan enrolment

If a staff member or retiree desires insurance coverage for his or her eligible dependants, he or she is responsible for ensuring that the required processes are followed within the allotted time frame for their specific situation. The staff member or retiree must ensure that he or she and his or her desired dependants who are eligible are enrolled in the plan if coverage is desired.

To ensure that information is provided to the staff member or retiree in a timely manner, the staff member or retiree must ensure that his or her contact details (e.g. mailing and email addresses) are always up to date in the relevant United Nations systems (Umoja, etc.).

Active staff members may confirm their enrolment by reviewing their monthly payslips or by accessing the relevant systems of their organizations to confirm coverage for themselves and their dependants.

It is the staff member's or retiree's decision to enrol or not enrol his or her eligible dependants. It is imperative that staff members and retirees review the present information circular in its entirety to ensure that the ramifications of not enrolling are well understood.

Plan knowledge

There are several avenues for staff members, retirees and dependants to obtain additional information regarding insurance provided by the United Nations. It is the responsibility of staff members, retirees and dependants to avail themselves of the information necessary to understand how the plan works and the process for seeking assistance. Below are several ways in which information regarding process, procedures, coverage and reimbursement may be found:

(a) Online registration on the insurance carriers' websites;

(b) Exploration of the United Nations website dedicated to insurance, www.un.org/insurance;

(c) Review of the insurance plan's applicable information circular;

(d) Review of the explanation of benefits to understand what was reimbursed, why it was reimbursed and what, if any, financial responsibility the staff member or retiree has.

Fraud prevention

It is up to each staff member, retiree and covered eligible dependant to ensure that:

(a) Submitted claims are processed correctly by reviewing all explanations of benefits received;

(b) Insurance cards are only utilized by the appropriate individual, which means that it is vital that insurance cards be kept secured;

(c) Insurance carriers are notified immediately when fraud is suspected;

(d) Patient portions for all treatments are paid when due, without exception;

(e) The consequences of fraud are understood. Those who are engaged in fraud will be reported to the authorities within the United Nations and the country in which the fraud occurred for appropriate action, such as non-payment of suspected fraudulent claims, suspension of any subsidy, termination of coverage, criminal investigation and other administrative actions, including termination of employment, for any staff member involved.

It is imperative that each staff member, retiree and covered eligible dependant is conscious of the costs of fraud, since the United Nations plans are self-funded, which means that fraud affects the Organization, staff members and retirees. The Organization and plan members, not the insurance carriers, cover all associated costs of the insurance plans.

Annex XII

Definitions

The following definitions are intended to clarify the meaning of certain terms that are used throughout the present circular:

Accident: The sudden action of an external force causing impairment of physical integrity.

Administering office: The office that has the responsibility for the day-to-day operation of the plan (for example, enrolment, collection of contributions from active and former staff members, premium accounting) at a given duty station.

After-service participant: Retirees, participating survivors and recipients of a periodic disability benefit from the United Nations Joint Staff Pension Fund and/or appendix D to the Staff Rules (rules governing compensation in the event of death, injury or illness attributable to the performance of official duties on behalf of the United Nations).

Annual campaign: Period during the year when a subscriber can enrol or terminate coverage for eligible family members after the original 31-day period following a qualifying event; the annual campaign takes place during a set period every year with the effective date of coverage being the first of July.

Co-insurance: A subscriber's share of the cost of a covered health-care service or expense that is usually calculated as a percentage of the allowed amount for a service. For example, if the plan covers 80 per cent of the reasonable and customary cost of a service, the co-insurance is 20 per cent or the share that the subscriber is responsible for.

Coordination of benefits: The settlement of reimbursable medical expenses where more than one medical insurance scheme covers a subscriber and/or his or her eligible family members (the instances when a health insurance plan of the United Nations health insurance programme is considered the primary plan are described in paragraph 43 above).

Dental services: Services performed by a dental practitioner or a dentist who is licensed to practise dentistry in the country in which he or she practises the profession.

Diagnosis: The identification by a licensed physician of an illness or nature of a disease.

Eligibility file: A file that is sent electronically to the third-party administrator that contains information on all active or retired staff members and their eligible family members who are covered under the plan; this file is the basis on which the third-party administrator determines who is eligible for coverage under the United Nations health insurance programme.

Eligible family members: A subscriber's recognized spouse and one or more dependent children, as defined in staff rule 3.6 (a) (iii). The United Nations Health insurance programme recognizes only one eligible spouse. A subscriber's children who meet the criteria for a dependent child under staff rule 3.6 (a) (iii), but for whom the staff member does not receive a dependency allowance owing to local limits on the number of children for whom a dependency allowance is payable, may also be considered as an eligible family member for the purpose of enrolment in the plan. In the case of an after-service subscriber, eligible family members are defined as the spouse and children already enrolled at the time of separation from service and any child born within 300 days of separation. A staff member's parents, brothers

and sisters, whether or not recognized as secondary dependants, are not eligible for the plan.

Emergency medical care: Medical treatments that are undertaken owing to an unplanned, sudden and acute illness or injury and which, for medical reasons, cannot be delayed or postponed.

Enrolled family member: An eligible family member who is enrolled in the United Nations health insurance programme.

Explanation of benefits: A statement that is sent to a subscriber by the third-party administrator that shows medical expenses claimed, reimbursement by the plan and any balances that are the responsibility of the subscriber. It may be sent by mail or email or as a downloadable document from the third-party administrator's website.

Hospital: An institution licensed by the Government to provide medical and surgical treatment and nursing care for sick or injured persons. Such care normally involves overnight stay (or inpatient care), thus requiring such facilities to have inpatient beds and continuous physician and nursing services under the supervision of licensed professionals. These facilities may also provide same-day treatments (outpatient care).

Inpatient care/treatment: Services provided to a person who has been admitted to a hospital and will stay one or more nights.

Medical information: Any information acquired by medical personnel, whether orally or in writing, relating to the physical or mental condition of any individual covered under a health insurance plan. For purposes of the proper review and administration of claims, such information may include, but not be limited to, diagnosis, physician's medical reports, results of diagnostic tests, treatment plans, prescriptions, etc.

Medical necessity (or medically necessary): All health-care services (that is, procedures, treatments, supplies, devices, equipment, facilities or drugs) that a medical practitioner, exercising prudent clinical judgement, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; (iii) not primarily for the convenience of the covered individual, physician or other health-care provider; and (iv) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

Out-of-pocket amount or expenses: The unreimbursed portion of recognized medical expenses (or co-insurance) that are taken into account in determining the application of the hardship provisions.

Outpatient care/procedures: Services provided to a person in a clinic, emergency room, hospital, medical or surgery centre or other facilities that does not involve an overnight stay in the facility. The patient receives care during the day and returns home.

Participating survivor: An eligible family member who survives a subscriber.

Physician: A person who is licensed to practise medicine by the authorities responsible for the territory in which he or she is practising.

Prognosis: A description of the likely course of a disease or illness provided by a physician, including the patient's chances for recovery.

Regional area of care: A country or region of a country generally neighbouring the duty station of the subscriber and enrolled family members that is specially designated by the United Nations where they can undergo medical treatment without the need for an approved medical evacuation. A regional area of care is designated solely owing to the lack of adequate facilities in the duty station or the country of the duty station. Medical expenses incurred in such areas will be reimbursed at the reasonable and customary rate of the designated location.

Reasonable and customary: The prevailing pattern of charges for professional and other health services at the staff member's duty station or the approved location (for example, the place of approved medical evacuation or regional area of care) where the service is provided.

Recognized expenses: The expenses for services claimed, provided they are found to be reasonable and customary at the duty station or, when obtained elsewhere in the country or at an approved medical evacuation location or regional area of care, at the place provided. If the expenses claimed are found to be above what is considered reasonable and customary, then the recognized amount for the purpose of calculating reimbursement is the reasonable and customary amount as reasonably determined by the third-party administrator.

Subscriber: An active or after-service participant enrolled in the United Nations health insurance programme or, upon the death of the former or the latter, the surviving spouse (if any) or the eldest eligible child recognized and receiving a monthly benefit from the United Nations Joint Staff Pension Fund.

Third-party administrator: An outside entity engaged by the United Nations for the processing and payment of United Nations health insurance programme claims.

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